Harvard Medical

ALUMNI BULLETIN WINTER 1996

Spelling Out the Future

National Institutes of Health

Fellowship Opportunities and Educational Loan Repayment

The National Institutes of Health (NIH) offers a variety of accredited clinical and basic research fellowships for physicians and other postdoctorates

- NIH has its own 500-bed research hospital and more than 1,000 laboratories in suburban Washington, D.C.
- In addition to attractive salary and benefit packages, highly qualified individuals may also apply for repayment of their educational loans. The NIH Loan Repayment Program (LRP) offers each awardee up to $20,000 annually in loan repayments and tax reimbursements.
- For more information, call the LRP at 1-800-528-7689.

WINTER 1996
VOLUME ~~69~~ 70 NUMBER 3

Harvard Medical
ALUMNI BULLETIN

Cover photo by Stuart Darsch

Harvard Medical
ALUMNI BULLETIN

When two or three doctors are gathered together, sooner rather than later the talk turns to the topic of "managed care." The term has become a code phrase among physicians, although its meaning is not yet fixed.

For many "managed care" refers to a set of satanic rituals involving domination, bondage and human sacrifice. For others the phrase merely connotes a world of diminishing opportunity and metastasizing bureaucracy. For some it represents an ideal—currently tarnished by its associations—of comprehensive care provided holistically, but with a judicious regard for the fact that any resource is limited and that medical care must ultimately be withheld, according to some principle of fairness, even from people who might actually benefit from it. Perhaps for most of us "managed care" is simply the catch phrase used to describe the tectonic shifts now in progress that will forever change the terrain of medical practice.

In a culture that honors business and deplores government, it is perhaps not surprising that the more comfortable term "managed" has been chosen in favor of "rationed," the more precise one, to describe what is happening to medical care. At 13.9 percent of the gross domestic product and rising, expenditures on health will, at least for the time being, have to be rationed. How that is done, and how humanely, remains to be worked out. The millenium may be arriving, but at the moment it doesn't look like much fun.

In this issue we look at the brave new world of medical practice through the eyes of Harvard alumni who have been living through and thinking about these great changes. We hope it will serve as a forum for the perplexed (to paraphrase Dr. Maimonides). We doubt it will help our readers to stop worrying and love managed care (to paraphrase Dr. Strangelove). In any case we expect to return to the topic in future issues of the *Bulletin*, if only because deceleration is nowhere in sight.

William Ira Bennett '68

ID Statement:
The *Harvard Medical Alumni Bulletin* is published quarterly at 25 Shattuck Street, Boston, MA 02115

Telephone: (617) 432-1548. Email address: bulletin@warren.med.harvard.edu. Third class postage paid at Boston, Massachusetts. Postmaster, send form 3579 to 25 Shattuck Street, Boston, MA 02115, ISSN 0191-7757. Printed in the U.S.A.

Letters

Piano Man

I am writing in response to the letter by Bert Bennison '41 in the Spring '95 issue of the *Bulletin* regarding the pianist he heard in Vanderbilt Commons, circa 1938 to 1940.

It is quite possible the talented pianist was my late husband, Richard Caddick '40. He had no need for sheet music because he played by ear. His occasional partner in a duet could have been Eddie Irons '39, a lifelong friend.

It is heartwarming to know that someone remembers the music of this talented man. In a cruel twist of fate, Richard was stricken with Parkinson's disease about ten years ago, bringing to a halt not only his piano playing, but his career as a surgeon. He died from complications of PD on December 14, 1994.

Thanks for the memory.

Doris Caddick

Moving Speech

I am deeply stirred by Jordan Fieldman's "Reflections from the Edge" (Fall '95). It must be one of the most moving pieces ever to be written by a young physician.

Edward L. Smith '38

Pulse

Aspirin Does It Again

Aspirin may never be taken for granted again; it will be taken to prevent heart attack, stroke or colorectal cancer.

Added to evidence that regular use of aspirin reduces the risk of cardiovascular disease is now substantiation that similar doses can cut risk of colorectal cancer. Women who take four to six aspirins per week for 20 years, it was found in an HMS study reported in the September 7, 1995 *New England Journal of Medicine*, can almost halve the risk of colorectal cancer. There is a slight reduction in risk after ten years of taking aspirin regularly.

Many well-documented studies have shown the protective effect of aspirin against colorectal cancer in men, but it had not been determined how much should be taken or for how long. This latest study analyzed the incidence of colorectal cancer among the 89,446 women in the Nurses' Health Study according to whether or not they used aspirin regularly. It controlled for diet, alcohol intake, smoking, family history of colorectal cancer, body-mass index and level of physical activity.

A similar dose to that found protective in this study—a 325-milligram tablet of aspirin every other day—is known to reduce the chances of cardiovascular disease by 44 percent in men and women over 50. Though, "The benefit for heart attack and stroke is immediate and we don't see the benefit for colorectal cancer until after a decade of use," said Edward Giovannucci, HMS assistant professor of medicine and lead author of the *NEJM* study.

Giovannucci and his co-authors speculate that aspirin may influence only the small-adenoma, early stage of colon carcinogenesis, which usually takes ten years or longer to become malignant. There are no established

Alex Itkin receives his white coat during the white coat ceremony at orientation.

mechanisms to explain how aspirin works, but it is known to impede the synthesis of prostaglandins, which among other things may regulate tumor growth. Aspirin also affects activity important in intracellular signaling.

More evaluation of dosage is necessary, say the researchers, particularly before recommending that everyone take aspirin to prevent cancer. But in an editorial in the same issue, Aaron J. Marcus, MD of Cornell and the New York V.A. Medical Center recommended that those at risk of colorectal cancer—with a family history of colorectal cancer; with inflammatory bowel disease; breast, ovarian or endometrial cancer; or a previous adenoma or large-bowel cancer—should take aspirin every other day, barring contraindications, such as stomach upsets or bleeding.

It appears that those who do will get at least two bangs for the buck, perhaps preventing cardiovascular disease as well.

Class of 1999

More students than ever before are applying to medical schools across the nation, despite the reportedly low morale and institutional flux the medical profession is now experiencing. Harvard is no exception to this upward trend: nearly 4,000 students applied to HMS this past year, an increase of 12 percent over last year's applicant pool.

The applicant pool is not only growing in size, but in maturity as well, in part because more people are choosing medicine as a second career. The oldest of HMS's incoming students is a 45-year-old woman who previously taught high school science. In speaking of the trend towards older students, Associate Dean for Student Affairs Ed Hundert '84 observes: "I think that the admissions committee is often impressed by the commitment that it takes for somebody to not only make the sacrifice that it takes to go through medical training, but to have the additional sacrifice of giving up their income and job."

Other notable students of the Class of 1999 include a midwife, a Peace Corps volunteer, and the first woman to graduate from West Point at the top of her class. Says, Gerald Foster '51, associate dean for admissions and chairman of the Committee on Admissions: "I'm always amazed not only at the academic accomplishments of the incoming class but with their extensive experience in community service."

Of the 166 students who constitute

Irwin Lee (left) and Lawrence Sullivan at orientation for the Class of 1999.

Orientation photos by Barbara Steiner

Edward Hundert and Dean Daniel Federman

Andrew Yee (left) and Janet Lee at orientation.

the Class of 1999, 85 are women, making this the second year in a row in which women are in the majority. Foster believes that one reason for this may be that women have particularly strong interviewing skills. As for the upward trend in medical school applications, Foster says that this may soon reverse itself, due to rising costs of a medical education.

In an effort to make orientation less intimidating for new students, they now meet with their second-year advisors the night before registration. Says Hundert: "Just about everyone starting had dinner in a small group with first- and second-year students the night before orientation. Most of us had the perception that the anxiety level this year seemed much lower as a result."

One orientation week activity reflects our high-tech times: the educational computing department arranged for all students to log on to e-mail boxes, where group messages were waiting for them.

Shaun Kumisaki (left) and Ben Gewerz

The Big and Small of It

There's a saying that goes you can never be too rich or too thin, and recent statistics on increased mortality of even moderately corpulent women appears to give a bit more, um, weight to the point.

JoAnn Manson, HMS associate professor of medicine and co-principal investigator of the cardiovascular component of the Nurses' Health Study, and colleagues reported in the September 14, 1995 issue of the *New England Journal of Medicine* that the heavier a woman is, the higher her risk of death from cardiovascular disease and cancer when compared to her leaner counterparts.

The study—which followed 115,195 women enrolled in the Nurses' Health Study aged 30 to 55 over a 16-year period—showed that women who weighed at least 15 percent less than the national average (i.e., an average height of 5'5" and weighing less than 120 pounds) had a slightly lower mortality than women even a few pounds heavier. Obese women, those who weighed more than 175 pounds at an average height, exhibited rates of death from cardiovascular disease four times that of leaner women and double that from cancer, especially of the colon, breast and endometrium. Manson's study also showed that women who gained more than 22 pounds since age 18 also suffered increased mortality.

"The most important public health message from this study," says Manson, is for women "to avoid substantial weight gain in adulthood." Women who gain more than 20 to 25 pounds have an increased risk of death from diabetes, cardiovascular disease and cancer. Manson advises women who have gained 10 to 15 pounds since age 18 to "view it as a warning signal" to prevent further weight gain and to make lifestyle changes that include more exercise and a heart-healthy diet.

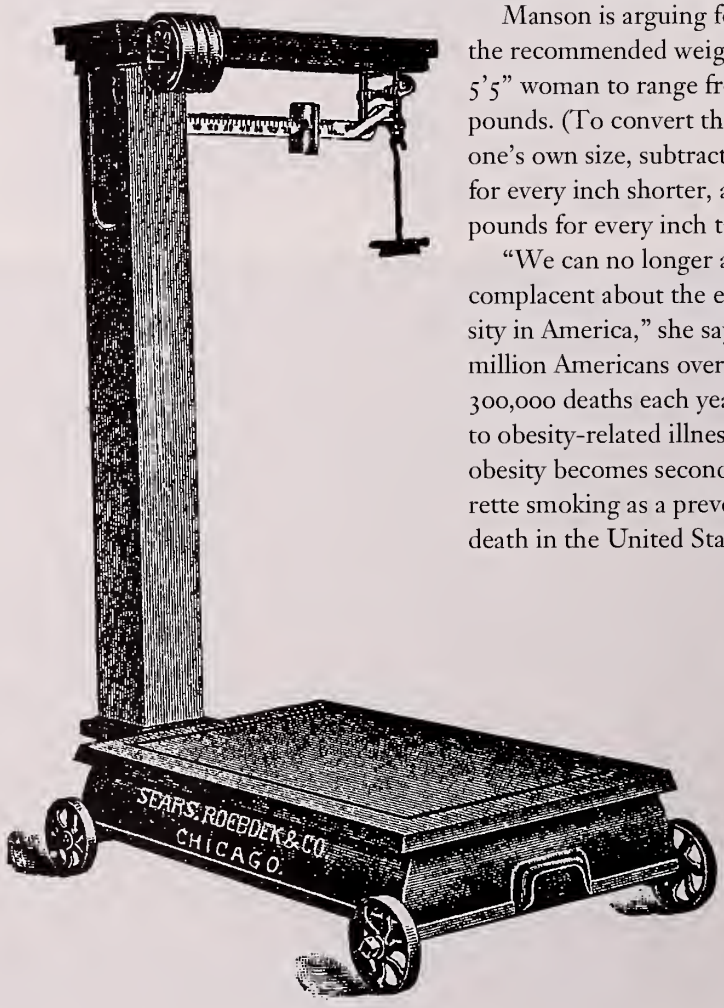
Manson's study contradicts some previous ones that found a relationship between leanness and increased mortality. Unlike this current study, however, the earlier ones did not control for smoking and underlying disease that may have caused weight loss. Very simply, smoking is more prevalent among leaner women than heavier ones, and thus their rates of death due to cardivascular disease and cancer are also higher. Furthermore, underlying disease, which could lead to death, could also cause weight loss.

Manson's study is significant not just because thin is in when it comes to living a longer life, but because as the country has gotten fatter (approximately one-third of the U.S. adult population is classified as obese), the scale of what's considered acceptable, healthy weight has correspondingly increased. In 1959, the Metropolitan Life Insurance Company tables listed recommended weights per heights that were up to 20 pounds lighter than those presented by the U.S. Department of Agriculture in 1990. For example, for a woman of average height of 5'5", the recommended weight ranges from 126 to 162 pounds in the 1990 tables.

"Even average weight in the United States is overweight," says Manson.

Manson is arguing for a revision of the recommended weight tables for a 5'5" woman to range from 110 to 150 pounds. (To convert this to match one's own size, subtract five pounds for every inch shorter, and add five pounds for every inch taller.)

"We can no longer afford to be complacent about the epidemic of obesity in America," she says. With 58 million Americans overweight and 300,000 deaths each year attributable to obesity-related illness, says Manson, obesity becomes second only to cigarette smoking as a preventable cause of death in the United States.



Meeting at the Crossroads

Patients faced with bewildering treatment options understand all too well how stressful it can be to wonder whether they've made the right choice. The creators of "Clinical Crossroads," a new monthly feature in the *Journal of the American Medical Association*, hope that in-depth discussions of those options may make the deciscion-making process easier, both for patients and for their physicians.

Steven Schroeder '64 of the Robert Wood Johnson Foundation—which is currently financing the project with a two-year grant—proposed the idea of a written series of clinical case studies to Thomas Delbanco, associate professor of medicine, who ran with it, but with the caveat that the patient perspective be given equal weight to the differential diagnosis. Editing the series with Delbanco are Jennifer Daley, assistant professor of medicine, and Janet Walzer, managing editor. In an editorial accompanying the column's July 5 debut, they write that Schroeder's goal was to make "case presentations that embrace the richness and complexity of caring for chronically ill, ambulatory patients."

"I hope it will help people to think more crisply," says Delbanco.

Each column profiles the treatment dilemma faced by one patient and the patient's primary care physician. Delbanco says they are most interested in chronic illnesses that have a high prevalence, thus prostate cancer and alcoholism have appeared already and future columns will focus on Parkinson's disease and low back pain.

Significantly, however, unlike their model of Richard Cabot's case records at the Massachusetts General Hospital—a tradition begun nearly 100 years ago and continued weekly in the *New England Journal of Medicine*—"Clinical Crossroads" wants the "individual patient to be front and center," says Delbanco. Therefore, each column extends its focus beyond just differential diagnoses to consider a patient's psychosocial, economic and environmental factors when making a clinical decision.

For example, in the first segment, a patient with newly diagnosed prostate cancer weighs his choice between two years filled with radiation therapy, debilitating enough to inhibit working on a book he is writing, versus undergoing prostatectomy, which would adversely affect his enjoyable sexual relationship with his wife. As the patient, who finally decided to do nothing, says, "I felt very comfortable with the decision I had arrived at, but I do think the decision was mine. It should be because I have to live with it."

To create each segment of "Clinical Crossroads," Delbanco and Daley videotape both the patient talking about his understanding of his dis-

Thomas Delbanco flanked by Jennifer Daley (left) and Janet Walzer.

photo by Barbara Steiner

ease and his options and the patient's primary care physician, who also talks about the patient's options, what specialists have said, and how he's leaning in guiding the patient.

The videotapes are then shown during a grand rounds at Beth Israel, attended by an invited specialist in the field, who is chosen through a peer-review process, the patient, his or her primary care physician, and several other physicians from various fields. Following the showing of the videotapes, the discussant reviews the literature, analyzes the situation and makes a treatment recommendation. Then everyone else chimes in. The entire proceeding is transcribed and printed in full in the journal.

Delbanco is developing teaching materials for medical students based on the "Clinical Crossroads." The editors are also preparing a letters section to be printed in a few months with the many varied responses—from one declaring that if his father had followed the advice in the column about prostate cancer, he'd be dead by now—to more positive ones. After a year, the editors will print a short follow-up about each patient featured in the column.

"I've learned a hell of a lot about medicine from these cases," says Delbanco. "And I hope the readers will learn as much as I have."

photos by Steve Gilbert

William V. McDermott (top) signs a card for Countway Library's 30th birthday. Below, Paul Russell, co-chair of the Joint Library Committee, Deans Daniel Tosteson, Bruce Donoff of the Dental School, and Harvey Fineberg of the School of Public Health, and Boston Medical Library President Grant Rodkey hold up commemorative t-shirts.

In May 1965, the Francis A. Countway Library of Medicine was dedicated, five years after HMS and Boston Medical Library decided to join forces. In October the library threw a birthday party to celebrate.

President's Report

by Stephanie H. Pincus

The Alumni Council convened for its first meeting of the year on November 2 and 3, 1995—dates carefully selected to coincide with the celebration of the 50th anniversary of the arrival of women at Harvard Medical School. The meeting began at the Harvard Club on Thursday evening with an introduction of new members. We welcomed Roman DeSanctis '55, Gilbert Omenn '65, Katherine Griem '82, David Gilmour '66 and Chester d'Autremont '44.

A diverse group of individuals joined the Alumni Council for a lively discussion of the Patient/Doctor course. The Patient/Doctor III course, as part of the third-year curriculum, attempts to integrate a self-analysis of the process of becoming a doctor with other issues related to clinical care. Considerable discussion focused on the preparation of "critical" incidents, which are individual case studies written by the students of key incidents that happen to them while on third-year clerkships, with their personal reactions and feelings. Several of these emotionally powerful essays were discussed in detail, with appropriate editorial comments by Dean Dan Federman '53 and Ron Arky, master of the Peabody Society, who provided insight into the motivating forces guiding these curriculum conditions. The sense of the group was that more attention needed to be paid to the interaction of medical students with hospital staff during the process of medical education.

Our work continued the next morning with an overview of our goals for the current year. The council plays an important role at Harvard Medical School by acting as a sounding board, reflecting upon proposed changes and issues in the medical school with the insight of alumni.

The concept of the Patient/Doctor course was strongly endorsed, however new pressures for distributing and realigning ambulatory care education may influence it. Proposed changes in the curriculum include ambulatory care education initiatives and modification of medical and surgical rotations to include more ambulatory care. We reviewed the feasibility of the proposal from our diverse perspectives.

Dean Federman reviewed medical school admissions. As always, Harvard has an enthusiastic, extraordinarily brilliant and talented group of first-year students. Not only is the medical school class increasingly female, but Dean Federman reported Gerry Foster's '51 assertion that women interview better and thus despite equal numbers and equal scores before the interview process, more women are admitted.

A good portion of the afternoon concentrated on financial issues. The students have been increasingly concerned about the amount of debt incurred during the Harvard medical education. A survey by two outstanding students, Carl Marci '97 and Thomas Roberts '97, has demonstrated that the increasing debt load not only influences specialty choice but also creates negative feelings toward HMS. Increasing attention will be paid by the council to assisting the students in finding creative ways to deal with financial issues.

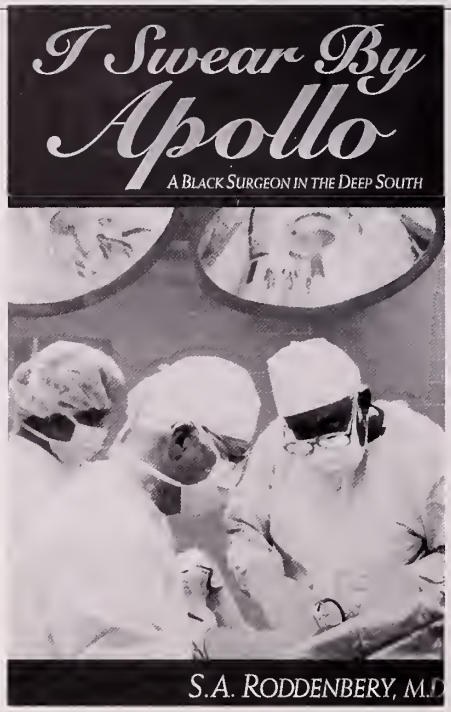
Clearly the next several years will be full of complex and contradictory currents requiring skilled management and nimble administrative balance. Cush Robinson, the new dean for resource development and public affairs, presented a number of new ideas related to the fund drive for Harvard. Expect to see new and creative appeals for your money and support in our re-energized development office.

The dedication of the Grete Bibring Conference Room in honor of the first woman professor at HMS was attended by many council members. This was one of the several activities celebrating the entry of women to HMS. The Saturday program, under the leadership of Eleanor Shore '55, is mentioned in other sections of the *Bulletin.* Let me reinforce the important role of alumni in this event and the even more critical role they provided as role models for the current students. The 50th anniversary celebration has been enormously successful and demonstrates a true commitment of Harvard toward women in medicine.

A number of lunchtime discussions focused on why women are perceived as better interviewees. We could not resolve the dilemma, but a number of allusions were made to Deborah Tannen's book *You Just Don't Understand* and to Carol Gilligan's ideas.

Stephanie H. Pincus '68 is professor and chair of the Department of Dermatology at SUNY Buffalo.

Book Mark



I Swear by Apollo
S. A. Roddenbery '42
Grandy Press, Hamilton,
Georgia, 1994.

by J. Gordon Scannell

At a time when there is so much wrangling about affirmative action, it is refreshing to read the personal record of someone who has gone ahead with his own affirmative project. *I Swear by Apollo* is a readable account by one of our alumni (a likely candidate for our unsung hero award) who admits that, "Having been born and reared in Georgia, I learned at an early age to hate Yankees and Negroes."

When Sam Roddenbery '42 grew up in Macon, segregation was the accepted mode. In four years at the University of Georgia, and another four years at Harvard Medical School, he "never saw or had contact with a black student." But like so many HMS students in the forties, he remembers a certain distinguished black Harvard professor, William A. Hinton, whose persona led Roddenbery to question the basis of his deep seated prejudices.

Forty years later, as he retired from active practice, Roddenbery delved into the life of another black surgeon, Delmar Edwards, and relived much of his own career, following the dictum of Stephen Vincent Benet:

> *Books are not men and yet they are alive,*
> *They are man's memory and aspirations,*
> *The link between his present and his past,*
> *The tools he builds with.*

The story begins in 1964 with Delmar Edwards's appearance in Roddenbery's office in Columbus, Georgia. Sam, then in his late 40s, shared an office and surgical practice with his medical school classmate, Abe Conger '42. Both were board certified, and both were still working hard to build their own practices and realistically not in a position to offend their patients and their medical community. Edwards was 38, not much their junior. He had just completed three years of a surgical residency at Tuskegee Veteran's Hospital. Roddenbery and Conger were consultants there, and they had found Edwards's work most satisfactory.

At this point Edwards had successfully negotiated with the American Board of Surgery to approve the completion of residency training by a two-year preceptorship arrangement under the direct supervision of Conger and Roddenbery, if they were willing. It was not an easy decision for the two surgeons; it was not an arrangement they would have initiated. After an evening of agonizing, they agreed.

They never had cause to regret their decision. Twenty-five years later Roddenbery set out to discover how Edwards, with limited resources and humble beginnings, survived and eventually reached his surgical goal in an ever threatening atmosphere. For reach it he did.

Delmar Edwards was born in Arkansas to a hardworking, modest-income family who had managed to survive the depression of the thirties by hard work and thrift. His education had been long and stubbornly won: church then public schools, a BS in 1948 from Wilberforce University, Ohio, after an extra year at Morehouse and two years as a medical corpsman in the U.S. Navy.

The navy experience set him on the long course to becoming a surgeon. His immediate objective was the University of Arkansas Medical School, tenuously desegregated. Before he could enter, he needed to arrange finances and find a benefactor. It took him five years, during which he taught at a number of colleges and earned a master's from Atlanta University. He had to deal with every shade of discrimination. Fortunately, growing up in a segregated society had taught him how to accept without servility but with dignified composure the reality of barbs, scorn and racial prejudice, not allowing them to distract him from his long-range goals.

In 1957 Edwards became the fifth black student to graduate from the University of Arkansas Medical School. Still, the long road to surgical training lay ahead: a one-year rotating internship in Winston-Salem and three years of general practice in Fort Smith, Arkansas to repay the man who had sponsored his medical education. For Edwards, as a black practitioner, they were years of frustrating and humiliating limitations. When he could stand the frustrations no longer, he paid off his obligations to his medical school benefactor and entered the surgical residency program at the Veteran's Administration Hospital in Tuskegee, Alabama.

By happenstance, Roddenbery and

Conger were surgical consultants to Tuskegee. Their contacts with Edwards were favorable. Therefore, when the American Board of Surgery required a further two-year preceptorship, Roddenbery and Conger were the logical preceptors—if they were willing to risk losing the affection of their friends, colleagues and patients by accepting the black and no-longer young Edwards as their associate.

Roddenbery and Conger were not social advocates, yet a sense of honor, consistent with the spirit of the Hippocratic Oath—"to teach them this art if they so desire without fee or written promise"—led them to accept the challenge. The playing out of that decision is the balance of the tale.

It is a tale well told though, as has been pointed out, in the adjustment to surgical practice in Columbus, Georgia, the incidents are predictable—snide remarks, slights and attempts to discredit. But this book is more than a catalogue of grievances. As Roddenbery points out in his epilogue, "From the beginning, it was obvious to Abe and me that in his daily living, Delmar would do everything within his power to create a situation in which young, well-trained black physicians who followed him would not suffer any of the indignities or deprivations he had experienced."

And, with Georgia as his stage, he did that.

J. Gordon Scannell '40 is editor emeritus of the Alumni Bulletin.

Me and My Shadow

As the last stop in the year-long celebration of women at Harvard Medical School, ten alumnae from the classes of 1945 through 1950 returned to the now renovated halls of their medical education to spend a day shadowing first-year women students to see how things have changed in the past 50 years.

"It's a totally new world," said Marian Woolston-Catlin '55.

They gathered early the first Friday in November in the MEC atrium and after the two groups initially headed toward others their own age, younger women and older began talking together. Eventually clusters of three and four formed and headed to the MEC amphitheatre.

There, in bright colors on the chalkboard at the front, was an invitation for students to participate in a benefit to raise money for AIDS, a fitting symbol of the many changes in medicine and in the life of students that would be seen throughout the day.

A lecture on the repair and replication of DNA moved quickly through a discussion about the three different structures of DNA (there used to be only one!), and alumnae discovered that more than just the announcements on the chalkboards had changed in medicine since they were students. "We barely had cell biology let alone immunology," commented Charlotte Neumann '54 later.

Following the lecture, the small groups toured the medical campus. "Should we start in the smelly part of the building?" asked Sarah Gelehrter '99 as she and classmate Beverly Aist led Woolston-Catlin up two flights of stairs to the anatomy lab.

"I don't think that much has changed," said Woolston-Catlin. She soon discovered, however, that that wasn't the case. Her class had been the first to have a female cadaver, to which Aist remarked that now the majority of the cadavers were female. Even their anatomy now is different. Given the widespread use of hysterectomy 15

Funding for Fellowships

The money for four fellowships in the 50th Anniversary Program for Scholars in Medicine has been raised. The goal is to raise enough for ten stipends a year. The program targets junior faculty who, at the point in their careers when they must begin competing for grants, publishing and, if clinical, practicing, may also be starting or adding to family responsibilities. This difficult combination of demands falls disproportionately on young women faculty.

Eleanor Shore '55, dean for faculty affairs and chair of the anniversary committee that initiated the fellowship fund, said her committee identified time and support as the two key factors junior faculty most require to stay on the academic track. The fellowships are an attempt to provide that.

Two fellowships in infectious diseases at the Channing Laboratories have been contributed by Amalie Kass, to be designated as the Edward and Amalie Kass Fellowships; the Harvard Pilgrim Health Care Foundation is funding one fellowship in honor of former HMS Dean Robert Ebert; and

years ago, a female cadaver would most likely have been missing her uterus, said Aist. "But ours had two cute little fallopian tubes and her ovaries."

One flight down from the anatomy lab, Gelehrter tapped a few buttons on a computer keyboard and a software program called "BodyRad" produced a complete description of the workings of a blood vessel, along with a picture of a cross section. Students Cindy Cooper and Joanna Steinglass, who were showing around another alumna, came in and brought up a computer image of the brain.

"All we had was an atlas that got pretty fragrant sitting next to the cadaver," said Woolston-Catlin, clearly impressed.

A seminar on the health of African-American women followed, which again illuminated how much things have changed. Fifty years ago, a class on women's health would have been an oddity, but one dedicated to minority women unheard of. As one alumna commented later, she and her classmates knew black and Hispanic women suffered a disporportionately lower health status than their white counterparts—still a reality today—but no one talked about it.

Lunch in the Courtyard Cafe provided time for alumnae to reconvene and share experiences. Cecile Forbes '55, who'd never been to Vanderbilt Hall, toured it with Meena Ranakrishnan. "I had to get on my bicycle and take the subway," said Forbes about how she used to commute to the Quadrangle, "while the gents walked right across the street. What do you think of that?"

Shadowers and shadowees came together the next day during a luncheon in the middle of a day-long symposium on women's progression in medicine during the last 50 years.

"There are more ladies' rooms than when we first came," said Renee Gelman '50. She also commented on the ethnic diversity that is such a dynamic feature of HMS classes today. In her class, she said, there were six women, one black and one Asian. "Yesterday was like the UN."

Gelman sat on a panel with her classmate Evelyn Davis Waitzkin and students Andrea Marmor and Annie Luetkemeyer.

"It was wonderful to see opportunities available to women today," said Waitzkin. "It all gives the impression that they have access to everything."

But Marmor and Luetkemeyer noted there are many changes that still need to be made for women at HMS. Marmor mentioned the low number of women on the faculty and the relative lack of research on women's bodies. Citing one example, in a recent lecture on the sympathetic nervous system in sexual response, "the whole discussion was about erection," she said.

Terri L. Rutter

the fourth fellowship is being funded by Charlotte and Irving Rabb in honor of Grete Bibring.

"The medical school faculty will be greatly strengthened when promising young faculty members can be encouraged and supported to continue their academic activities during the most stressful years of competing demands," says Shore. "Both the faculty and the students will be the beneficiaries when the senior faculty cannot only represent the best of teaching, research and patient care, but also can reflect the diversity of the current medical school student body."

TR

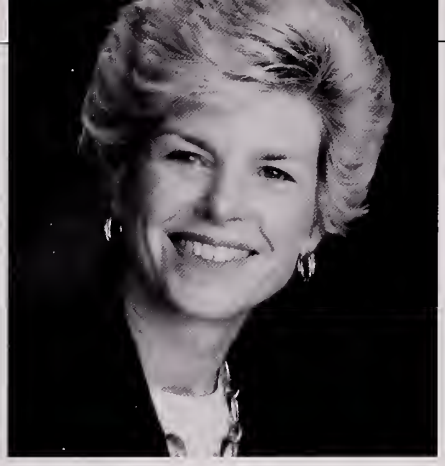
New Head for Development

In introducing the new dean for resource development and public affairs to the Alumni Council, Dan Federman '53 said he purposely would not refer to A. Cushing Robinson as the answer to all the school's financial problems. Since starting in June 1995, she has often been introduced that way, perhaps jokingly, perhaps all too hopefully. The school is operating with a deficit and faces unprecedented reductions in federal support, and though one person cannot be expected to hold the only key, a strong fundraising program is in fact critical.

Since arriving, Robinson has been actively pulling together the leadership staff necessary to reach the medical school's $220 million portion of the university's $2.1 billion campaign, developing a fundraising program that "will have the structure and flexibility to raise money for the medical school well into the twenty-first century." Thus far in the three-year campaign, the medical school has raised $122 million—well on the way toward reaching its goal by 1999.

Though she shrinks from attention focused solely on her, she does acknowledge that she has experienced enough ways of raising money that have worked that "I feel we can apply them here in an effective way." She comes to HMS from the University of Pennsylvania Medical Center and Health System, where as associate executive vice president for development and alumni affairs she planned and successfully implemented a $500-million fundraising campaign. Prior to that, she was deputy director of the Fund for Johns Hopkins Medicine and co-managed a $250-million campaign.

Seeking foundation and corporate support is part of her agenda, but her major strategy is identifying individuals "who have made their money and



feel an obligation to pay back society." The challenge is to find people interested in the cure and prevention of disease, "individuals who want to influence the future of this great educational and scientific enterprise."

Robinson feels a particular mission about strengthening financial aid. At University of Pennsylvania, one donor's gift of $10 million initiated an endowed scholar's program, which has generated enough money that 24 students now attend medical school there tuition-free. "Most importantly it served as an inspiration to other alumni and friends to contribute in a major way to support financial aid."

This could be done here, she told the Alumni Council (who have been grappling with how to help students reduce mounting debt). "But we would need one or several major donors—with a commitment of at least $30 million—to begin to make a difference."

She pointed out to the alumni councilors that the unit loan required is higher here than at other top medical schools, that is, the amount of financial need a student must show before becoming eligible for Harvard scholarship funds. If $30 million were raised, that could reduce significantly the unit loan, which in turn would significantly reduce students's debt burden. The majority of students now expect to graduate over $100,000 in debt. As for the pipe dream of a tuition-free medical education for all students, that would take the creation of a $400-500 million endowment.

Some money from the current campaign will go to financial aid, but she emphasizes that to address this problem at the $30-million level, "We need a major, major donor."

Clearly there are many challenges. "In this time of proposed federal cutbacks for research and in medical education, private support becomes not only increasingly important, but essential to the well being of the school," Robinson emphasizes. "An effective and productive resource development program is absolutely critical."

What Robinson says she relishes most about her job is garnering the support of individuals in pursuit of a common goal and then to see that goal achieved. "My pleasure comes from the synergy of putting all the pieces together—like all the mechanisms of a watch, which when everything is in place, can then begin to record time."

Ellen Barlow

The Maze of Managed Care

by Thomas Bodenheimer

At 2:30 A.M. comes the first call. I open one eye and reach for the phone. "ER calling: an Aetna patient with leg pain. You're the primary. Are we authorized to see him?"

"Of course," I mumble. "Managed care. Stupid calls in the middle of the night."

At 2:50 the phone rings again: "Fractured tibia. Which orthopedist should we call?"

"Who's on call for the ER tonight?" I ask.

"Dr. Pettibone."

"Is she on Aetna?"

"We don't keep an Aetna list here; that's the primary's job."

"I don't keep a list under my pillow either; call Dr. Pettibone and I'll handle it in the morning."

The nightmare has just begun. As I walk into my office later that morning, Aetna is on the line. "Dr. Pettibone's not on our list. Why did you authorize her? The patient needs surgery. Find one of our orthopods." Seven calls later—from Dr. Pettibone's office, three from the patient, one from the patient's mother, and two from Aetna—I'm an hour behind in my schedule and fuming. It takes my office manager five calls to locate an Aetna orthopedist to see the patient that day. "Managed care" ruins another day and reduces access to care for another patient.

Thousands of physicians across the country could recount similar vignettes on a regular basis. My small group practice contracts with ten HMOs through three independent practice associations (IPAs) and thereby suffers from an unending stream of such silly episodes. But are these idiocies deserving of the term "managed care?" Managed care sounds like something good—the coordination of a family's care through a primary caregiver, who provides or arranges an appropriate and efficient array of services. The fractured tibia incident would better be described as "damaged care." But wait a second. Are we saying we want to return to the "good old days?"

photo by Stuart Darsch

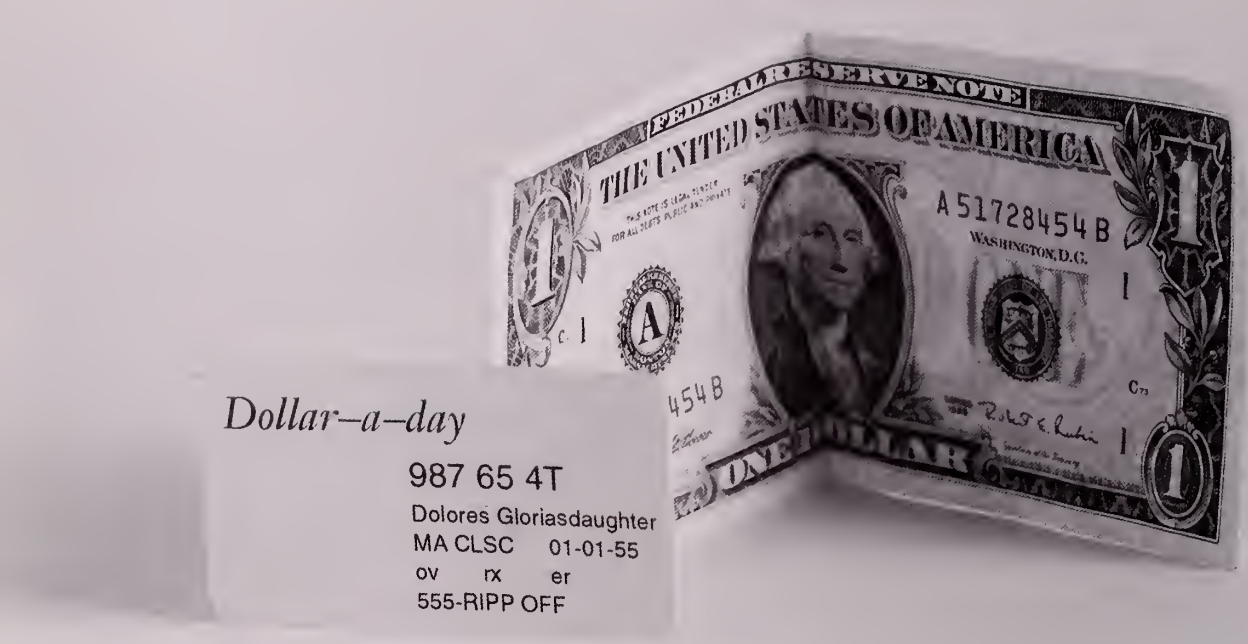


photo by Stuart Darsch

The traditional model of care

She wanted everyone to call her Gloria; she felt her life was glorious. She had good health insurance and her only dealings with the medical care system were through her gynecologist, who delivered three children at Uptown Hospital and performed Pap smears and breast exams. The gynecologist, not trained to consider the full spectrum of preventive health issues, never asked Gloria about her smoking and high-fat diet.

At age 56, things changed. Gloria suffered a myocardial infarction and was discharged from Downtown Hospital in atrial fibrillation and congestive heart failure on captopril, digoxin and coumadin. She continued to see a cardiologist who was busy, competent and businesslike.

One day Gloria sprained her ankle and a friend brought her to an orthopedist at Crosstown Hospital. She was placed on ibuprofen. Two months later Gloria fell to her living room floor in a syncopal episode, after which she felt severely nauseated, with fatigue and anorexia. The cardiologist had warned her to call if she had chest pain, shortness of breath or ankle swelling, but these were not her symptoms. Gloria's husband, who suffered from an ulcer, arranged for his gastroenterologist to perform an upper endoscopy, which was normal. Ibuprofen was stopped but the nausea persisted.

Finally, at her regular cardiology visit, Gloria was found to have an elevated creatinine from the combined effects of captopril and ibuprofen on the kidney, a digoxin level of 3.5, and complete heart block. When the offending drugs were discontinued, Gloria felt relieved that she was still alive and wished she had a physician who knew all her problems and could coordinate her care.

Gloria experienced the dispersed model of medical care that dominated American medicine for decades. Were the good old days that good?

Under the dispersed model, many people lacked a physician with generalist training. Care was often provided by specialists whom the patient—perhaps upon a friend's recommendation—would contact directly. Depending upon the location of specialists, patients might attend several hospitals, without centralization of medical records. Preventive care was downplayed because no provider felt responsible for the whole patient or coordinated multiple independent sources of care.

How did the dispersed model affect Gloria? She did not benefit from preventive interventions that might have delayed her heart attack. Lacking a primary care provider who could assess her polypharmacy, she fell victim to a near-fatal drug interaction. She and her husband were left to figure out which specialist should handle the problem of nausea; they guessed wrong and she underwent an unnecessary endoscopy while the risk of sudden death remained.

Can the organizational problems demonstrated by Gloria's case be solved? Can "managed care" solve them? And what do we mean by "managed care?" Perhaps we must distinguish between managed care as cost control and managed care as rational organization of services.

Managed care as cost control

Gloria's daughter, Dolores, had her first headache last week. Working as a receptionist, Dolores was enrolled in Dollar-a-Day HMO, a for-profit health care conglomerate. During her first year on the job, she had enjoyed seeing a physician assistant at another HMO, but six months ago the employer canceled the HMO contract and Dolores had to leave her primary care provider.

When the headache persisted, she called her new primary care physician but was unable to obtain an appointment for a month. One night, the headache became unbearable and she went to the nearby hospital emergency room. After calling the

primary care practice, the nurse informed Dolores that the ER visit was not authorized and suggested that she call her physician in the morning. Not sure who denied the care, Dolores did as she was told.

Three days later, Dolores arrived at the primary care office. During a brief consultation with the physician, she was given a medication, with a follow-up visit in two weeks. The headaches worsened. At her next visit, Dolores's requests for an MRI and neurology referral were denied, and the physician spent no time inquiring about social stresses that may have contributed to the headache. Instead, the medication was changed.

A friend later explained to her that many physicians in managed care earn bonuses by denying care to their patients and that many HMOs are making millions in profits and are spending only 75 percent of the health care dollar on medical care. Dolores's headache remains undiagnosed.

Under her managed care plan, Dolores's care is centralized with one primary care provider. But continuity of care, central to the primary care gatekeeper concept, is fragile because her employer has the power to change her health plan and thereby her health care provider. Moreover, the primary care physician is not easily accessible, perhaps due to the capitation mode of payment, which pays as much for an empty office as for a full one. Access to other services is limited, an apparent by-product of financial concerns of the HMO and the primary care physician. Difficulties with the dispersed mode of health care delivery are superseded by a seemingly worse set of problems.

What can we learn from Dolores's case? Health care has been reorganized for the purpose of saving money, not in order to make care more rational and efficient. The goal of saving money is laudable; the health care system is drowning in waste. But the money saved seems to be making its way to a new breed of health care investors, CEOs and consultants. The manipulations of health care financing designed to control costs can hurt patients.

For clinicians, the danger is paramount. Many capitation arrangements pay bonuses to primary care physicians if they block patients from emergency visits, specialty consultations, diagnostic tests and hospital days. For-profit HMOs may reward hardened gateshutters and penalize thoughtful gatekeepers. Is managed-care-as-cost-control—dangling the lure of the dollar—engineering a metamorphosis of the primary care physician from caring clinician into evil executioner?

A clear distinction must be made between, on one hand, the capitation-plus-bonus method of paying physicians nurtured by many for-profit HMOs and, on the other hand, a system based on salaried physicians, more typical of group and staff model HMOs. Under managed-care-as-cost-control, which tends to employ the capitation-plus-bonus payment mode, the main goal is to save health care dollars using a primary care gateshutter, rather than to allow patients access to a gatekeeper who provides basic care and coordinates specialized services. In the process, the system may elevate the economic side of physician human nature and deemphasize the clinical side: the clinician is being turned into "homo economicus."

These are strong statements. Perhaps they are one-sided. Indeed, the system is damaged but not altogether broken. The creation of primary care gatekeepers would be a major step forward if the perverse financial incentives could be eliminated.

The movement away from hospital stays toward home care is positive. The attempt to reduce unnecessary care represents a major advance, but it must not be taken to an extreme nor linked to economic greed. Moreover, financial greed was not invented by the capitation-plus-bonus payment system; it was also nourished by the fee-for-service milieu of the dispersed health care model.

Might the seeds of true managed care sprout within the current ill-conceived system? Can we imagine a rational structure of managed care in which continuity and coordination of care is the main goal, with cost savings a secondary by-product? In fact, a reasonable managed care model, as described by Carolyn Clancy and Howard Brody in the *Journal of the American Medical Association* (January 25, 1995), can be "found among the older staff model health maintenance organizations that were established in the 1940s through the 1960s, when cost containment was an unexpected benefit rather than the central purpose."

Managed care as rational organization of services

Bryan Lerner, a graduate student, enrolled in Apple-a-Day HMO, a health care cooperative owned by the enrollees and managed by a patient-elected board. Bryan chose a primary care provider who was salaried by the HMO's neighborhood clinic near his campus. Following his enrollment, Bryan received a letter from the clinic suggesting that he wear seat belts when he drives and never mix alcohol and automobiles. He was made aware of an evening smoking-cessation class and was invited to come in for a blood pressure and cholesterol check. The letter included a list of the major causes of death for males his age. Because his mother had diabetes, he decided to go for the preventive visit and meet his primary care provider.

One day Bryan, riding his bike, was hit by a car. An ambulance brought Bryan to the nearest general hospital. After performing a neurologic exam, skull x-rays and a head CT scan, the emergency room physician diagnosed a depressed skull fracture with a cerebral contusion. The choices were admission to the general hospital versus transfer to the Apple-a-Day regional neurosurgery center 12 miles away. The latter course was taken since Bryan was medically stable and the tertiary care facility had more experience in handling complex head trauma.

Bryan went home five days after his neurosurgery with intensive home nursing care and physical therapy. He recovered completely, though he developed diabetes during the ordeal. He received follow-up care for his anti-convulsant therapy and diabetic man-

agement through his primary care physician, with occasional consultations with a neurologist and yearly retinal exams by an ophthalmologist. Because Bryan's HMO premium is paid by a universal health insurance system, Bryan does not worry that an employer will force him to leave Apple-a-Day.

Apple-a-Day is a staff model HMO that salaries physicians and tries to minimize the care-reducing incentives of Dollar-a-Day HMO's capitation-plus-bonus system. Care is regionalized, with many neighborhood primary care clinics, a few secondary care general hospitals, and one tertiary referral center per metropolitan area. Care is provided at the most cost-efficient and appropriate level; thus Bryan was discharged from the hospital after five days and received most of his post-surgical care at home.

Preventive services are provided to the entire enrolled population with the goal of improving the health status of both individuals and populations. Physician payment does not depend on providing more or less treatment, allowing the volume of service to be set principally by patient need rather than by economic incentive. In contrast with the Dollar-a-Day physician, the Apple-a-Day physician is less "homo economicus" and more "homo medicus"—a happier state of affairs for both patient and physician.

Let us not think that Apple-a-Day is utopia. Controls on physician-enrollee ratios may limit access to timely appointments and create demands on physicians for more productivity and fewer minutes per visit. But without the strong economic incentives of the capitation-plus-bonus system, gatekeepers are not as inclined to pride themselves on being gateshutters.

Patients enjoy long-term continuity of care because health insurance is separated from employment through a publicly-funded universal health insurance system, thereby allowing for personal, rather than employer, choice of health plan. The weaknesses of the uncoordinated, dispersed model of care are corrected without creating all the problems of managed-care-as-cost-control. As a by-product of coordinated, efficient care, but not as its main raison d'être, Apple-a-Day saves health care dollars for society.

The Apple-a-Day model, which approximates proposals for health care reform made by Arnold Relman, embodies my vision of managed care. The nation's current rush into a distorted managed-care-as-cost-control, which may tragically turn clinicians into businesspeople dressed in white coats, is a sad spectacle that the American public and medical profession would be well advised to condemn and reject.

Thomas Bodenheimer '65 practices internal medicine in San Francisco and teaches health policy at University of California at San Francisco School of Medicine. He writes a series of articles on health policy for JAMA and is co-author with Kevin Grumbach of Understanding Health Policy, *an introductory text for clinicians based on patient vignettes (Appleton and Lange Publishers, Stamford, CT, 1995).*

photo by Stuart Darsch

"Who are you?" greeted his wife when **Ernest H. Picard '55** came home on time for dinner after his first day in a new job. In 40 years of practice, he had rarely been home for dinner on time. But a year and a half ago he made a career change from a private practice in neurology at Massachusetts General Hospital to working full time as associate medical director of Pilgrim Health Care, a Massachusetts HMO, and now he is home most nights.

It wasn't an abrupt change, since he had been a physician advisor at another HMO part time, but it was dramatic nonetheless. This is not what he went to medical school to do. "Most of us went into medicine because we like patient contact and thought we were going to serve," he says. "This is no longer part of my work." But he does find his new job stimulating and exciting, though in a different way from private practice.

What led him to this apparent about-face approaching age 65? The story may be familiar to many.

The running of his solo practice had become burdensome financially—as overhead costs rose, reimbursement was falling precipitously. "I could see a meeting of the lines." Though his three children were already through college, he still had enough financial pressures that he took on an extra job as associate medical director at a nursing home. "My days were never ending." He left home at 7:30 a.m. and "it was not at all unusual to return at 1:00 a.m."

Precertifications and reimbursement hassles had become increasingly bothersome and time-consuming. He would do a consult on a sick patient transferred from a community hospital, but because the patient had already seen a neurologist there within ten days, the third-party payer wouldn't reimburse him. "I'm of the old school. Take care of the patient first and worry about reimbursement later."

Other patients came from outside the Boston area for a procedure only done at MGH, but since their primary care physician hadn't referred them, he wasn't reimbursed for consulting. "This must have happened 20 times in the last six months of my practice," says Picard. "It was almost easier not to bother filing for reimbursement. I was providing more free care than you could shake a stick at, but not usually for the uninsured or other deserving patients."

It became clear to him that something had to give. He could retire, but he didn't want to just sit at home. He knew he had something more to offer and could build on what he already knew. Starting in the seventies, he had become involved in Mass. General's utilization review process, and that activity had expanded, leading to some advisory case review for an HMO, the part-time physician advisory work, which in turn evolved into the job offer from Pilgrim Health Care.

As it happens, his wife, Joyce, is a career couselor who helped him face his fears of a career change. She helped him write a good resume and supported him with examples of other professionals she had counseled who switched careers ("though generally they were not doing it at my age").

As one of three physician associate directors for Pilgrim, he now spends each morning on site at any one of a dozen or so hospitals, reviewing medical care of members with the HMO's nurse. When he gets back to the office, he handles precertifications and appeals, calls physicians about their patients, and attends the inevitable meetings.

"I'm the messenger of the contract the patient has with the HMO," he says. Though he is very aware that physicians consider this a waste of time, he says that as he gets more caught up in this, he understands now that, "This is 1995, this is the reality." Economics are important: "Though that was not on the medical school curriculum in 1955!"

He also feels better about being on "the other side" because he can bring a useful clinical perspective to decisions. He can help the nonmedical administrators who run the plan make decisions on new drugs and procedures. Also, at this HMO, only Pilgrim physicians—not clerks—make calls to other physicians, an effort to reduce the frustration of dealing with someone who doesn't understand medicine.

Picard finds his days interesting and has no regrets. And what tops it off: "It's been nice to get reaquainted with my wife."

Ellen Barlow

The Kaiser Experience

by Bruce J. Sams

"The secret of the care of the patient is in caring for the patient."

Francis Weld Peabody
"The Care of the Patient"
Doctor and Patient, 1930

Illustration by Richard Cook

"My 30 years of experience in health care delivery absolutely convince me that physicians should aspire to winning back their role as the leaders in health care delivery."

"System and Efficiency"—these watchwords of modern American business life, are beginning to be adopted by what used to be called the 'learned professions' and medicine, in particular, is entering a period in which 'organization' and 'service' seem destined to play a prominent and perhaps somewhat exaggerated role."

"The Public and the General Practitioner"
Doctor and Patient

FRANCIS PEABODY, A MUCH BELOVED professor of medicine at Harvard and director of the Thorndike Laboratories from 1921 to 1927, has provided us with many perceptive and pertinent observations in the slim volume, *Doctor and Patient*. Two of these observations, printed 65 years ago, are especially appropriate as we assess the tumultuous changes occurring in health care today. His prescription for caring for the patient has provided a sensitive insight for several generations of Harvard Medical School graduates. His second observation, more prosaic, reminds us that the changes we are now seeing have not simply burst on us overnight.

My own experience with what is today referred to as managed care began 30 years ago. As a member of the Permanente Medical Group, the physician part of Kaiser Permanente in Northern California, I was part of or

close to many of the changes leading towards organized systems of care.

My interest in Kaiser Permanente developed out of my frustration with the inadequate health insurance available to patients in my solo, fee-for-service practice in Savannah, Georgia. In those days hospital coverage was inadequate, and ambulatory coverage even more so. I missed the resources available to me as a house officer at the MGH. When my turn came to present to our monthly journal club in Savannah, I decide to review the subject of health insurance (not part of my curriculum at dear old HMS).

I read with interest about Kaiser Permanente and the concept of prepaid comprehensive insurance. Here was a system with comprehensive coverage in which the physician was free to order and prescribe according to the needs of the patient. I flew out to see the program first-hand, liked what I saw, and eventually joined the Permanente Medical Group as an internist/hematologist in San Francisco.

The Permanente Medical Group, Inc., is a professional corporation. Each physician is a shareholder with two, and only two, shares of stock. We independently choose our physician members, our physician leadership, our methods of practice. We monitor our own quality of care. In HMO parlance, we are a group model HMO. The medical group is largely responsible for the success (or failure) of the program since we have the leading role in providing access, quality and cost effectiveness, and control the expenditure of most of the funds.

We contract exclusively with Kaiser Foundation Health Plan and they work exclusively with Permanente Medical Group. This contract, among other things, spells out the responsibility of the medical group to organize and provide medical care without interference by the health plan. The nonphysician Kaiser side of the program has its own critically important responsibilities in planning marketing, finances and legislation, but these responsibilities do not include the practice of medicine or control of the medical group.

Cost containment was an important byproduct, resulting from the fact that the best care was the least expensive.

In my experience, physicians did not join Permanente because of a passion to practice cost-effective medicine. On the contrary, most enjoyed the opportunity to practice without having financial concerns impinge on the doctor/patient relationship. Cost containment in Kaiser Permanente was not the primary objective of the program—it was an important byproduct, resulting from the fact that the best care was the least expensive. For most of my years with Permanente, we generated lower costs than the fee-for-service system with which we were competing simply by doing only those things necessary for the patient. Those days are gone, of course, and in this highly competitive world Kaiser Permanente is deliberately and avidly seeking specific strategies for increasing efficiency.

Prepaid group practice, as it existed in the San Francisco Kaiser Permanente Medical Center, was pleasant indeed. I enjoyed the contact with other physicians, the ability to seek and give consultations without additional charge to our patients, and the presence of an active staff and house staff educational program. Our structure and traditions encouraged mutual support and friendship among physicians.

We perceived ourselves (correctly I believe) to be grievously misunderstood. Our colleagues in fee-for-service generally did not understand that we were an independent group practice, but believed we "worked for Mr. Kaiser." Even less accurately, they described us as "socialized medicine." Not so. We were a large private sector organization, an alternative to socialized medicine, not a part of it. While we had a social purpose—to provide high-quality care at a reasonable cost—we were part of a competitive, free-enterprise system.

We believed the quality of our care was as good as the community's, if not better. Unfortunately, in the absence of any reliable measurements of quality or outcomes, our critics were able to argue that if fee-for-service cost more, it must be better. These critics were very convincing. So successful were they in convincing themselves of our deficiencies that they were blind to the large numbers of their patients who were joining us. They also failed to see the need to put their own house in order—a costly error, as events are proving.

Life within Kaiser Permanente was not universally idyllic. Some physicians found group practice restrictive. Although our medical group was reasonably democratic, democracy by definition meant that the majority opinion prevailed, and some individual views were overridden. Physician incomes, while on a par with many community physician incomes, did not match the super incomes that were rumored to exist in fee-for-service practice. Physician resignations, however, were rare (about 1 to 2 percent per year) once the individual passed the three-year trial period and became a shareholder.

From its inception, Kaiser Permanente had a keen sense of social purpose, a belief that we were serving a community need by making health care accessible and affordable. Our program had its seeds in the 1930s, a time when many patients could not afford access to medical care. A num-

While we expected physicians to 'manage' their patients and their resources, we did not advocate having nonphysicians 'manage' physicians.

ber of responses to the access problem evolved, including prepaid group practices, health cooperatives and fraternal groups. These were mainly private sector solutions, in which responsible people organized and used insurance principles to pay for their own care and thus maintained their own dignity.

Because these primarily working people had limited resources, efficient use of these resources meant more dollars available for needed care. Physicians and hospitals in many of these ventures became partners with patients in trying to conserve resources. Being not-for-profit, Kaiser Foundation Health Plan rates were set to meet the needs of our patients, not to maximize income. In Northern California during the 1960s, seventies, and much of the eighties, we often charged less than we could have in the prevailing market.

For many years now Kaiser Permanente has been hailed as one of the leading examples of "managed care." This is somewhat ironic, because managed care as it is currently developing differs considerably from the original concepts on which our program was founded. We did not refer to ourselves as managed care. We were a "pre-paid group practice." While we expected physicians to "manage" their patients and their resources, we did not advocate having nonphysicians "manage" physicians, as the term often seems to imply today.

We staunchly advocated not-for-profit organizations with very strong physician leadership as we do today. Managed care today is trending toward for-profit systems with weakened physician involvement. Many physicians have lost considerable autonomy and control over their practices and are angry, frustrated and discouraged.

For-profit systems are not new to health care or necessarily undesirable. My own small fee-for-service practice in Savannah was a for-profit venture, as is the Permanente Medical Group, Inc. Of more pertinence are the purposes and pressures driving the organizations.

Delivery systems need capital, which is quite frequently furnished by investors. Many observers are concerned that investors will put unreasonable pressure on systems to generate unreasonable profits. Indeed, many for-profit systems have been started in immature markets in which they have been able to make very significant profits. Through a combination of competition, a sense that health care is more than a business venture, and the increasing influence of physicians, it is hoped that the for-profit sector can and will be socially responsible.

For-profit organizations would be making a politically smart long-range decision if they kept executive incomes, administrative costs and other expenses within reasonable levels. In any event, as competitive markets become mature, huge profits for investors will be a thing of the past and profits should approach the usual return on invested money in other areas.

Any organization, for-profit or otherwise, competitive or governmental, that puts restraints on our past exuberant spending will win no popularity contests among those restrained. We should remember that our choice is not between competition and the old

Our choice is not between competition and the old open checkbook, but between competition and some other method of cost control.

open checkbook, but between competition and some other (probably governmental) method of cost control. While the competitive model is showing some clearly undesirable current trends, the fact that it can change and be changed emphasizes the advantages of a private-sector delivery system.

Unfortunately, physicians generally have not accepted responsibility for leading today's changes in health care delivery. Physicians have been educated to be intensely interested in the problems of their individual patients, but less so in the problems of the community as a whole, and of the systems under which they practice. They have believed that if they took good care of their patients, society would provide adequate rewards and security. Society, if it ever made that promise, is reneging on it today.

The essence of the problem, as I see it, is that many health care systems believe they can operate most efficiently by "managing" the physicians. The antidote to that unhealthy concept is to demonstrate that organizations in which physicians have significant influence can provide better quality, access and efficiency. If physicians can indeed make physician-led systems more competitive, then investors will seek out these more competitive systems in which to invest,

and the necessary capital will flow readily to them—the better mousetrap analogy.

The next few years will test, in the marketplace, the theory that physicians given responsibility for a delivery system can indeed do a better job. Will this beautiful theory be destroyed by ugly facts? We shall see. The test is already under way. The outcomes of hundreds of "experiments of nature" in delivery systems will define the place of physicians in these systems. My own program, Kaiser Permanente, will be stressed by a variety of competing systems. We have a strong physician organization with which to face the future, but I predict that we must improve, then improve again, and probably improve many more times in order to stay ahead.

Needless to say, physicians have an immense stake in how the experience with physician-led organizations works out. The results are not predestined, but can be shaped by physicians who understand the issues and are willing to lead the change.

Physicians should keep their eye on two major challenges. The first is to make sure that some form of private sector solutions work. It would be ironic if those physicians who prefer a private health care sector became so antagonistic to managed care that they were to give up on a private sector solution, leaving the field to government. The second challenge is to see to it that the successful solutions are ones in which physicians have significant responsibility.

Some readers may view this call for more physician responsibility simply as physician jingoism or perhaps a spasmodic twitch of the old guild system. Possibly some slight element of both are present. However, my 30 years of experience in health care delivery absolutely convince me that physicians should aspire to winning back their role as the leaders in health care delivery, and to the extent that they do, their patients, society and they themselves will all be better off.

The challenge is to see to it that the successful solutions are ones in which physicians have significant responsibility.

If I were entering practice today I would look for an organization in which top quality physicians had significant ownership in, or at least major responsibility for, the delivery system. Some established group and staff model HMOs fit this bill. Many newer varieties of organizations are being developed that encourage physician ownership, physician responsibility and physician risk sharing. In addition to these desirable attributes, my preferred organization would have a realistic chance for long term economic survival, so as not to leave me high and dry several years down the road, in the midst of a doctor surplus, with no practice of my own.

Finally, I would assure myself, either through contract or ownership, that the organization could not break its agreement with me simply to serve its own purposes. If I could not find an organization that fit these criteria, then I would explore with my colleagues how we could form one that did. Physician arrangements with delivery systems are becoming more exclusive, tying the success of the physician to the success of the system. Selection of the health care delivery system in which to practice will be one of the major decisions young physicians will face in their professional lifetimes.

Many of my contemporaries believe the golden age of physicians is over, and are glad they will not have to grapple with the future. I don't share that view, in spite of the issues discussed above. If I had the proverbial three wishes, I would wish for a trustworthy golf swing, a big pot of money to give to the Harvard Medical Alumni Fund, and the privilege of starting out as a newly-minted physician again.

Physicians in the next 30 years will have the skills and tools to be far more effective in treating patients than we were. Furthermore, I have faith that "systems and efficiency," correctly harnessed by physicians, will significantly enhance their ability to truly care for their patients in the manner Francis Peabody so wisely prescribed.

Bruce J. Sams '55 was a member of the Permanente Medical Group in Northern California from 1963 to 1993 and held a number of administrative positions, including 15 years as executive director. He is currently serving on the HMS Alumni Council.

Karl Singer '67, a family practitioner in Exeter, New Hampshire, let out a sigh of relief when his five-member practice group merged with the newly-formed Lahey Hitchcock Clinic in January of 1995. He was relieved to no longer have to expend the money, time and effort involved in meeting the demands of four highly complex pieces of legislation—OSHA, the Clinical Laboratory Improvement Act, Americans with Disability Act and RBRVS. He was relieved not to have to update his computer system (which handled the billing and insurance claims for his practice); relieved to no longer have to keep track of the money his group had collected from patients the day before, or deal with the uncertainties of a fluctuating salary (he now receives a regular paycheck). Singer can now devote the majority of his time to medicine rather than the business of medicine.

Most of all Singer was glad to no longer have to wrangle with insurance companies—Medicare in particular. (Lahey Hitchcock took on all of his patients, 40 percent of whom are dependent on Medicare). As medical director of the journal *Patient Care*, Singer wrote an eloquent letter to Hillary Rodham Clinton that described the following experience with one of America's largest medical bureaucracies:

"The enclosed statement and check from Medicare are powerful symbols of why doctors are so discouraged. I saw a new patient, a man in his 70s, at a nursing home on March 4, 1992. I submitted a charge of $45 for this initial evaluation. The claim was rejected by Medicare, then sent on for review. After one year the patient, long since dead, received a check from Medicare. It was for one penny.. . ."

Singer was not alone when he made the decision to leave private practice behind. He was part of what he describes as a "loose coalition" of primary care doctors in solo and small group practices in his community, many of whom took slightly different routes, such as merging with the local hospital or a statewide HMO. Singer and his medical group did a lot of shopping around before they decided on the 800-member Lahey Hitchcock group.

Far from regretting his decision, Singer says, "I'm excited about it." He feels that he has little to lose and much to gain: "We've tried to keep our own institutional identity, maintain our autonomy." At the same time they've benefited from sharing information and patients with other partners in their multispecialty group.

They chose Lahey Hitchcock because it's physician-run. It has a long history of quality medical care and is interested in making the same medical practice changes that Singer's practice is. Perhaps most importantly, he likes the people he now works with at Lahey Hitchcock.

Sarah Jane Nelson

photo by Paula Singer

Careers in Crisis

by Terri L. Rutter

photo provided by Personality Photos, Inc.

Assembly line workers in Charlie Chaplin's film "Modern Times," 1936.

"PHYSICIANS HAVE THE DEGREE OF autonomy of a line-worker but the responsibility of an executive," says Gigi Hirsch.

Hirsch's frustration as an emergency medicine physician for five years brought her to this conclusion and she began asking what went wrong, and where? Why was she so unhappy? Had she chosen the wrong specialty or had she, bite her tongue, chosen the wrong profession altogether?

Hirsch did what many physicians in her position do: another residency, this time in psychiatry. Yet upon finishing three years ago, her feelings about the state of medicine and her place in it were still unsettled. When physicians around her were echoing her own disillusionment, Hirsch began thinking that the problem was not just that she and her colleagues were disgruntled, but that the system of health care delivery in which they worked was the root of much of their distress.

"Individuals don't cope well with systems that are crazy," says Hirsch. And this system is definitely crazy, she believes.

With seed money from Beth Israel Hospital and blessings from its president, Mitchell T. Rabkin '55, Hirsch founded the Center for Physician Development to help other physicians either avoid the mid-career crisis she experienced, or at least negotiate their way more confidently through it, and also to create a feeback loop of information to health care managers. CPD, an off-site program of the BI, provides services to hundreds of physicians nationally as well as to large health care delivery systems, insurance companies and professional organizations.

"Physicians are reevaluating things," says Hirsch. In this environment of managed care, doctor-bashing and insurance-company directives on patient care, "the bureaucratic element is overtaking the doctor/patient relationship."

So what's a physician to do? How do physicians manage in what more and more of them are seeing as an unmanageable situation? "It's not as simple as that doctors just want to jump ship," says Hirsch.

Unlike professionals in business, physicians aren't encouraged, or taught, how to evaluate their careers as they go along. "The model they have is that they should be happy doing what they're doing and when they're not, they feel that they have failed," says Hirsch. "Many come in and say 'I don't know what I need; I just know I'm unhappy'."

Some, says Hirsch, have come to realize that they chose the wrong specialty early on, "but the ball just keeps rolling forward and there's no point at which they just say, 'that's enough'." Others may have financial woes but Hirsch emphasizes that the monetary issue has been overplayed in the media and is not central to many physicians' unhappiness. Others despair the 15-minute interview, feeling it doesn't give them enough time to do what they most enjoy: spending time with their patients. Many physicians, however, touch on the same set of issues, all of which have been introduced by manged care: loss of control over their daily work lives and, primarily, outside interference with their clinical judgment from people with inadequate medical knowledge and experience upon which to base their critiques.

"The human aspect of the work is being eroded," says Hirsch. Many physicians express the same sentiment: that the "intrinsic satisfaction," that sense of "going home at the end of the day and feeling that you have made a difference in people's lives" is wearing away. Physicians are not only frustrated and unhappy about how to manage themselves and their career interests within the vagaries of managed care, but they also don't know where to turn to learn.

CPD, therefore, provides a unique sextant to physicians in offering career consultations. With the use of testing instruments and ongoing dialogue, Hirsch and her colleagues from the fields of organizational development

and behavior, systems reengineering, management consulting, conflict negotiation, psychology and psychiatry help physicians make decisions about how to get unstuck. Sometimes it's as simple as just airing how they feel; other times it involves changing their work environment completely, or perhaps just trying to find ways to get involved in other interests or responsibilities, such as doing clinical research, teaching or consulting in industry.

The consultation begins with a comprehensive questionnaire for the physician to fill out beforehand. Hirsch developed the list of questions out of her own personal exploration. "These were the questions I was asking myself, and the questions I wished someone was asking me, or had asked me," she says. It includes such soul-probers as "When did you first decide to become a physician?", "What were your main reasons for choosing a medical career?" and "If you had it do over again, would you choose to go to medical school?" It also asks more pragmatic questions, such as the number of working hours a week one is comfortable with and what salary would be considered equitable.

For some people, says Hirsch, just answering the questions is enough; it gets them focused on thinking about actual issues and problems they may be having and helps them understand where to focus.

"CPD does not have the 'answer' for you," emphasizes the organization's literature. "[It] makes every effort to equip you well for your internal and external exploration process...the ultimate answers, though, lie within you...."

Strict confidentiality is maintained at all times: "Right at the front door, some of them are so ashamed to be calling for help that they give us a fake name." Hirsch does share the experiences of one client, however, who said: "I guess I expected that at the end of this session today, you would hand me a card telling me, for example, that I should be a fireman. And then I'd walk out of the building and there would be a fire engine, red hat, and a Dalmatian waiting for me!"

But all the career counseling, personal validation and introspection in the world won't change what Hirsch and her colleague Barry Stein, director of consulting services, claim is an outdated and demoralizing system of health care delivery. Stein is co-president of Goodmeasure, Inc., an international consulting firm, whose clients have included Ford, Digital, IBM, AT&T and Kaiser Permanente.

"The current system is irrational," says Hirsch.

Hirsch and Stein wrote an article for a publication of the American Medical Association entitled *Legal Advisor* in which they quote an anonymous medical director of an anonymous HMO: "The doctors don't really work for us. It's not our job to provide them with (personal and professional) supports. The hospitals will handle those things. Or the professional societies will. Or the doctors themselves. If a doctor is having problems, it usually shows up in our Utilization Review process. And then we just get rid of them."

Such an attitude is not the way to run a successful business, says Stein. Indeed, the organizational structure of the health care delivery system today with its top-down management, known as the control orientation, and the reduced participation of its actual physicians (and others) in decisions is so outdated that "the best of corporate America left it behind long ago," he says.

Stein compares the current organizational system of health care delivery to economist Frederick Taylor's theories in the early 1900s of industrial management, whereby the manager handed out sharply defined and unified tasks, such as shoveling coal, to the worker, who did his task the way he was told, collected his wages and went home. Huge immigrant populations guaranteed a steady supply of replacements for those who didn't return the next day, so management had no need to maintain worker satisfaction and since the tasks were limited, it was easy to train replacements. Workers never became managers and, obviously, vice versa.

As times changed, especially after World War II, companies had to change their ways. Workers became not only highly educated—like their managers—but also wanted to be more invested in their companies. Their tasks were more intricately interconnected with those of others who worked with them and, organizationally, they developed a sense of the whole operation in which they were involved. For managers, this situation was inherently more difficult to control than were the coal shovelers of the past. But this was replaced by workers' personal commitment to their organizations and products. Managers also came to understand that their workers were highly skilled and thus not as easily replaced as were their less educated forebears.

The health care industry, however, has not kept up with the times, says Stein. "By and large people talk a lot about teamwork, but they're using Taylorist work designs and outdated systems."

Hirsch and Stein believe this is one of the major factors creating physician dissatisfaction. "Many of the intrinsic rewards of medicine are eroding," says Hirsch, listing the most frequently aired complaints: not having fun anymore, loss of control over daily work life, interference with clinical judgment.

"No truly committed physician can achieve his or her goal in this crazy system," says Hirsch. "In fact, it's normal, it's appropriate for them to be demoralized right now if they're really committed to providing excellent care to their patients."

So what to do? Beyond counseling individual physicians, Hirsch is motivated to change the system itself by taking the information and insight she has gained from them and presenting

it to "those organizations that provide the girding of support for the system": medical schools, residency programs, professional medical societies and the insurance industry.

But, says Stein, "it's been a hard sell." Foundations aren't interested in funding projects concerned with physicians, professional organizations aren't set up to do this, and medical schools and residency programs are built on long-standing traditions themselves resistant to change.

Naysayers, however, are going to have to begin paying more attention, argues Hirsch. She points to the rising number of physicians filing for disability as a harbinger of other signs of physician distress. (In a January 1995 article in the *Wall Street Journal*, the Unum Life Insurance Company of America, a major insurer of physicians, reported that its disability claims had jumped 60 percent in the first six months of the previous year.) And though the vast majority of physicians "who are burned out and demoralized" will not file such claims, she says, it's even more worrisome what is happening to them.

"You can see that their spirits have been broken. They provide adequate care certainly, but their passion is missing and clearly, just intuitively, that's got to have some effect on the quality of care and the quality of the doctor/patient relationship."

And ultimately, argues Hirsch, that will also have a more substantial impact on medicine overall and where medicine is going.

Terri L. Rutter is associate editor of the Harvard Medical Alumni Bulletin.

Joan Goldberg '70 went right from a fellowship in hematology to Harvard Community Health Plan, where she has spent 21 "consistently positive" years. She is now director of HCHP's AIDS program and practices hematology at the Kenmore Center.

Though most of her classmates went into private practice or academia, she knew that wasn't the route for her. "I knew I didn't want private practice," she recalls. "I was too disorganized. I wanted structure." HCHP had started four or five years before and, based on reports from physicians she knew there and its "excellent reputation," she decided to sign on. "It was an exciting new adventure."

The job also provided the flexibility she needed those first ten years of her career, when she had first one, then a second child. She worked part time then—half of it in internal medicine and the other half in hematology. She didn't have to worry about filling her practice, either; as the first woman in internal medicine to join the Cambridge Center, which had just opened, her practice filled immediately!

As she wrote in her 25th-year reunion report: "We have been able to offer our patients the latest in high technology as well as compassionate personal care, without having to justify our actions to an unknown bureaucrat, without excessive paperwork, and with the knowledge that our patients are covered for all their care."

Even though HCHP is much larger and more bureaucratic than in those early days when everybody knew each other, many other people like her have stayed a long time. She knows many of the people at higher administrative levels. As for working in a staff model HMO: "Philosophically if feels better to me than to work in a more strictly capitated system. I truly feel that virtually none of my salary is based on what I order for my patients."

Less than 10 percent of a physician's salary is based on how the plan as a whole is doing, and cost consciousness is encouraged, but she is emphatic that any emphasis on cost savings has nothing to do with what care is provided a patient. HCHP doctors try to get patients in and out of hospitals quickly through greater efficiency in scheduling tests and getting back results, and by setting up home care plans.

This is particularly important for her AIDS patients. "Members have access to a wide variety of specialists, social services and to experimental protocols in the Boston area," she says. "I never feel a pressure not to give the best treatment that is known, even if it's experimental."

The only downside she can think of is that with the recent focus on the negatives of managed care, patients tend to be more cynical about accepting clinical decisions. "It is harder to have a good doctor/patient relationship when a patient assumes we are trying to save money."

Goldberg is not at all surprised that her professional choice 21 years ago turned out to be the right one. She sees patients, runs a program, teaches students and house officers, and members of her department have a close affiliation with hematology/oncology departments at the Beth Israel and Brigham and Women's hospitals. She didn't want to be an academic, but finds all the intellectual stimulation of an academic environment. And she doesn't have to devote time to grant applications like her husband, Alfred Goldberg, HMS professor of cell biology.

Ellen Barlow

Changes in the

Hungry for an Answer

by Joshua Sharfstein

Disclaimer: all stories not having to do with food are absolutely true.

8:00 am
Wake up feeling hungry. Head to kitchen. Remember my decision three months ago to pay for 150 breakfasts up front. My goal: to train for future professional survival by literally living, breathing and eating prospective payment. So I went to one of those discount stores and bought a huge crate of rye bread and a bucket of strawberry jam.

Open refrigerator. See rye bread. Imagine same old smell of strawberry jam. Get dressed and head to the gourmet market. Thank God for fee-for-service sector in bagels. Need a good breakfast. Today, I am finally going to decide what I think about managed care.

9:00 am
Back at home. Settle into comfortable chair and close my eyes. Convene a meeting in my mind of all the physicians I have known in my three years of medical school with strong opinions about managed care. Seems like a good place to start.

First to talk is my resident in plastic surgery. During one slow clinic afternoon, he had told me: "I have been training now for seven years after medical school. Now I'm nearly done, and because of managed care, there are no jobs here for me. They should be lining up to give me jobs. I don't apply." But

A General Trend

By Sarah Jane Nelson

When Associate Dean for Student Affairs Edward Hundert '84 addressed the Alumni Council this spring, he mentioned that there is a growing number of graduates choosing general medicine, and particularly family practice. Since 1990 there had been only two or three students per year going into family practice, but in 1994 there were four and in 1995 there were seven. While some HMS alumni are uncomfortable with this move away from specialization, others feel that this is a healthy change.

Hundert, who has studied career-choice trends extensively, says that the growing popularity of general medicine at HMS reflects a national trend. "The percentage of the class going into general internal medicine was 33 percent last year. If you

Ambulate to Educate

by Ellen Barlow

"The current changes in medical education are the largest since the advent of clerkships," says Daniel F. Federman '53, HMS dean for medical education. Though there's debate about whether the content of what's taught should change to reflect the evolving practice environment, *where* future doctors are being trained is already changing.

The transition to teaching in an ambulatory setting, explains Federman, is comparable in significance to when teaching gravitated to the hospital bedside in the second decade of this century. Education before the Flexner report had been preceptorial. Medical care, aside from that of the poor, had centered in patient's homes, not hospitals, which prior to knowledge of sepsis were dangerous places to be.

Now, as patients are being shepherded quickly out of the hospital or into ambulatory settings, the trend in teaching is following suit. Though more a national trend in medical education at this point, it has had a foothold at Harvard for some time. Since 1987 there has been a two-month core clerkship in ambulatory care, for which students are placed at Harvard Community Health Plan, in neighborhood health centers, and at the teaching hospitals. But faced with further changes in the delivery of health care, it is thought by many at HMS to be clearly time to integrate training more adequately in all disci-

Amphitheatre

with nobody in line, his only plan was to sign up for two more years of specialized surgical training.

"Your mistake was not choosing primary care." Practically jumping out of his chair to talk is my first clinical teacher, a community internist who spoke of the future as if quoting the verse "and the meek shall inherit the earth." He explained to me: "In the old days, I would refer a patient to a specialist, never hear back, and maybe six months later the patient would come back with one kidney, or having had a heart operation, or just never come back. Some of those guys never answered my calls. Not any more. Now we control the patient's care. Josh, the future is ours."

So I ask the crowd: "Do opinions about managed care depend on whether you are a specialist or a generalist?"

"Not at all!" says one of my surgery preceptors, breezing into my mind wearing surgical scrubs, arguing that HMO medicine has finally paved the way for more rational decisions to operate. A neurologist in "The Plan" also rises to speak: "Remember when I told you how happy I was to never ask any of my patients if they have insurance?"

And then the unhappy cohort of community doctors arrives. One pediatrician, who worked for an HMO, was almost fired simply because the company had just lost a major contract. A psychiatrist was even more frustrated: "I am being forced by these rules to provide terrible care."

The session ends. And I conclude: those

include med/peds (they are actually becoming internists as well) then, in fact, 37 percent of the class is heading for internal medicine. If you look back over the last several years, it hasn't been that high since 1987. And if you include pediatrics (8 percent) and ob/gyn (7 percent), then you've got more than half the class going into primary care specialties."

Hundert points out, however, that these statistics are somewhat misleading. HMS graduates who choose pediatrics, for example, often end up as subspecialists—pediatric oncologists or pediatric endocrinologists—after completing their residencies. Similarly, "In the past, some 80 percent of our graduates who went into internal medicine did a fellowship and became cardiologists or gastroenterologists or pulmonologists, and they don't count, in the government's statistics, as

plines into settings in which students will perform their future jobs.

As one of several efforts to increase the proportion of teaching in ambulatory settings, the dean appointed a Task Force on Ambulatory Teaching, chaired by Anthony Komaroff, professor of medicine. The task force has assessed the current state of ambulatory teaching at HMS—the variety of ways the different disciplines are or are not mixing inpatient and outpatient teaching—and has recommended new rotations and a longitudinal primary care clerkship to provide opportunities for continuity of care. But there are grave hurdles to face first.

"The pedagogic planning is under way, but whether and how to do it are not resolved," says Federman. "Whether education should be based on the setting is one question. There are other issues not at all resolved, such as faculty participation and facilities; this comes up just as both are beleaguered."

The availability of faculty to teach and facilities to teach in, in fact, is of much broader concern than just for ambulatory teaching. Medical schools have always depended on the willingness and availability of faculty to teach. But, points out Federman, "Now it tests more their willingness. Most faculty are seeing cutbacks in their incomes and feel simultaneous pressure to see more patients in shorter times for less income." Basic science faculty have greater difficulties than ever before getting grant support and are devoting more and more time to writing grant proposals. The end result: "We are scrambling for faculty who will teach."

doctors most eager for managed care are the ones who feel empowered, while those who feel controlled dread the future. Which will I be?

12:00 noon
Getting hungry again. Go to kitchen for food. I had set aside lunch as a memorial to the bygone days of fee-for-service medicine. Recall memories of gourmet dining from early in the year. Maybe I ate too much in those days; lunch budget used up by last month. Take out some rye bread and strawberry jam. Kind of tasty.

Go downstairs to get mail. Today I receive yet another invitation to "train in a capitated setting." For weeks now, the new HMO residency programs have been sending me descriptions of how I can become "a physician of the future." At least the HMOs sending me applications seem responsible. What if those for–profit HMOs causing million–dollar scandals in Tennessee and Florida offered residencies?

Imagine the brochure: "In your first year, you will be exposed to all parts of our system: emergency care (for which we do not reimburse), primary care (if your patients can find your clinic) and utilization review (our program is the best in the country). Second year, you don't just train with specialists—you are the specialists! Third year—well, to be honest, we don't expect to be around third year."

2:00 pm
Time for the afternoon session—the patients speak about managed care.

"Thank God I wasn't in an HMO," one well–dressed man told our first–year class. He related the story of how a referral to an ophthalmologist saved his four–year–old son's life. One of my classmates then asked him whether his job was in jeopardy while he was caring for his child. "Oh no, I'm self employed as an investment advisor," he told us, "and if any of you have some spare cash, invest in HMOs. They are hot."

primary care doctors."

Hundert believes that the move away from specialized medicine is largely motivated by job market forecasts. Medical students are intelligent people who keep up-to-date with developing trends: "The fact that fewer people are going into radiology than used to means that they read the newspaper and find out that that is not where the jobs are going to be."

It's the growing managed care environment that has led medical graduates to train as both generalists and subspecialists. "HMOs and group practices want to hire primary care doctors who can also cover endocrinology if they don't have an endocrinologist on staff." What's more, Hundert adds, "Many can't afford to hire somebody who's just an endocrinologist, who can't also take a panel of primary care patients."

Hundert noted another educational trend that is in direct response to the spreading managed-care environment: "There are

Teaching hospitals have always accommodated medical education as a somewhat implicit cost, he further notes. "But with the pressure to be competitive and shave costs in order to bargain for patient shares, medical student education may be expendable."

Then there is the question of whether the content of what's taught should change to reflect the realities of the workplace. There have been unprecedented changes in the managing of care and payment, in the degree of oversight of physicians' work. To what extent should the financial realities be brought into case discussions; should the 15-minute interview, rather than more comprehensive case history, be taught; should students be oriented somehow to the different practice environments that await them?

Federman is quick to point out that the emphasis in education is on understanding the mechanisms of science that underlie clinical medicine, on understanding the phenomena and learning the skills necessary for excellence in clinical practice. Only thirdly is cost brought up. "There is no question that cost is given much more attention than before in the Patient/Doctor course, discussions of cases, and in clerkships. It has rightly influenced the material we include, but it is not the emphasis."

He also points out that there has always been a debate or a tension around the degree to which undergraduate medical education in itself should prepare people for practice. Generally the thinking at HMS is that education should remain an introduction to clinical and basic science as a base for the rest of one's professional life—a clinical readiness for practice but not specific preparation.

"In the past, however, there was no doubt that the graduating student had more control over what he or she would do—an image of finishing training and starting an office," says Federman. "That is very different from today's image of being hired and salaried."

It had taken me a month to recover from the irony.

"Well, thank God we are in an HMO," said the wife of a patient admitted in diabetic ketoacidosis to my medicine team last spring following a drinking binge. We had been prepared to send him home a few days after admission, but his HMO physician put her foot down. "He needs immediate counseling and psychiatric follow-up or he'll just wind up right back here," she said. Two phone calls later, she had arranged a session for the following afternoon with a therapist who knew him well, and he stayed the extra day.

The patients rise to speak one after the other—and most of their comments fall into one of two categories. Either they have chronic or common complaints and they are praising their HMO for rationalizing treatment and enhancing outpatient services, or they have a more difficult-to-diagnose or serious condition, and they are furious their HMO puts up roadblocks to their care. Even in the best HMOs, there are winners and losers.

What will make all patients winners?

5:00 pm
The sun is setting over Longwood Avenue and I am barely closer to making up my mind. Can I get some perspective here?

I ponder the recent attempts of organized medicine to keep its own head above water. Under virtually every scenario, there will be thousands of unemployed specialists, and there may even be a few extra primary care doctors. No wonder the profession wants laws to allow doctors to join together and compete with insurance companies. These measures are important to ensure that physicians—and not investors—can control health care.

Yet there is much more to this transformation than economics. Even in physician–run plans, there will be pressures to undermine the quality of care. Will the

now a number of courses that take cardiologists, endocrinologists and gastroenterologists [for example] and retool them for primary care." While the "status" of primary care medicine at HMS (and Johns Hopkins, Yale and other academic communities) is still relatively low compared to the specialties, this career choice is gaining some invaluable role models. At HMS Tom Inui, head of the Department of Ambulatory Care and Prevention, has developed a mentorship program for students who choose the general medicine route. Robert '66 and Suzanne Fletcher '66, senior professors in that department, also serve as role models. Hundert says, such physician-teachers have proven that you can become an academic and a generalist.

Hundert also believes that the increasing number of students interested in practicing primary care, in many cases, transcends pressures from the job market: "There are national statistics that suggest that older students are more likely to go into primary care careers, as are people

Almost certainly now, he says, doctors will be part of large organizations that make group decisions as to patient care, finance and practice patterns. There is less time per patient. Cost is a dominating factor. To what degree should undergraduate medical education be dealing with these factors?

"These are not just practice issues, they are moral ones," says Federman, who rattles off some of the new questions medical educators face. In an expanding profit-oriented environment, how do you preserve for education and its ethos the appropriate values? How do you exert influence on a company of a thousand physicians where the decisions are made 1,000 miles away?

Students are applying to medical school in record numbers, despite changes in the profession. These future doctors are at the heart of the issue of what impact the changing professional environment will have on education. The reason so many want to go into medicine is what makes them and the integrity of the profession so vulnerable, believes Federman.

"Most students come here with an altruistic motive, some with a commitment to community service or to caring for the underserved," he says. "I have always thought that this is a terrific part of medicine. But the ruthless competitiveness among health care providers and the for-profit ethos undermines this sense."

Also, the debt burden of medical students today is enormous—14 students last June graduated with debts of over $100,000. In the past, says Federman, the assumption was that if you lived long enough, your marriage didn't break up, and you got through educating your kids, that your income would catch up with your loan obligation. "Now it is increasingly difficult to expect that students will ever make enough income to discharge debts, and we're not talking about living at all extravagantly."

Some things are immutable, however. Harvard Medical School is here

medical profession fight for patients as for itself? Jerome Kassirer, editor of the New England Journal recently predicted: "Soon, many [doctors] will find themselves conforming to the restrictions and deceiving themselves that what they are doing is best for their patients."

Thanks, Dr. Kassirer. Now that's something to look forward to after residency.

7:00 pm
Confused and depressed. And hungry. Confused, depressed, hungry.

Try one last mental trick. Close my eyes and envision the future. Keep looking. Keep trying. Can't see much. Very blurry. Could be anything. Had a feeling that wouldn't work.

Open eyes and look in mirror. So what do I think about managed care? It is a canvas on which doctors and patients paint hopes and fears. It is the best of times for some, and the worst of times for others.

But my future in managed care is another question. It will depend partly on choices our society makes, and partly on how the medical profession maintains its ethical obligations. But ultimately, my experience with managed care will depend on one person and one person alone.

And that person wants dinner now.

Joshua Sharfstein '96 is not looking forward to choosing a health plan once he starts residency in pediatrics next summer.

from rural areas."

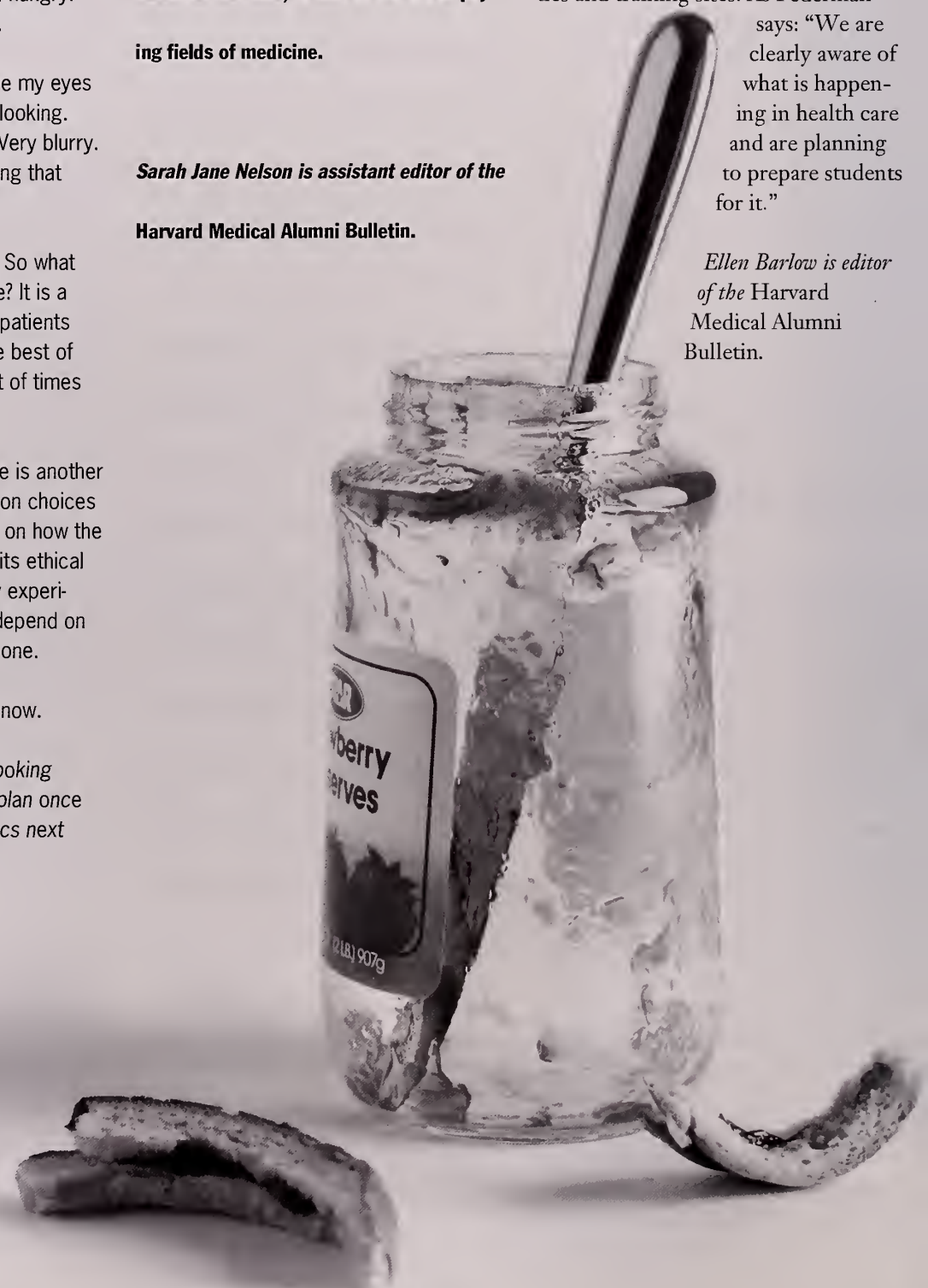
All of this points to a large element of altruistic motivation. How else to reconcile this choice of the older student, who often has a family to support and other large financial burdens, to one of the lower-paying fields of medicine.

***Sarah Jane Nelson is assistant editor of the* Harvard Medical Alumni Bulletin.**

to stay and students will continue to come to learn, ask questions, and value high standards of evidence and patient care. "We are not changing the curriculum to a short circuit of what it stood for in the past," asserts Federman.

But the New Pathway was devised as a dynamic curriculum that could evolve with the times. Re-evaluation of the clinical curriculum is taking place, as are analyses of faculty responsibilities and training sites. As Federman says: "We are clearly aware of what is happening in health care and are planning to prepare students for it."

Ellen Barlow is editor of the Harvard Medical Alumni Bulletin.



Linda Lyons '80 graduated from medical school at the dawn of managed care. But now, she says, "I'm certainly in the thick of it."

Lyons is senior vice president of resource management and managed care operations at Scripps Clinic Medical Group in San Diego, California. Scripps Clinic, a 300-physician multispecialty group practice in 11 clinic settings throughout San Diego County, provides fully capitated health care services to over 90,000 enrollees with five health plans. She is also the chairperson of Unified Medical Group Association (UGMA), a national trade association representing over 80 group practices and nearly 5 million capitated enrollees. She is also a member of the board of directors for the Medical Quality Commission, a national quality and accreditation body.

She's thought a lot about managed care. First off, she cautions that the language for this new system of health care delivery can be confusing and misleading. "I bristle at the term managed care," she says, "because it may be inaccurate depending on how it is used. Largely, insurance companies manage costs. It takes physicians to manage the care. The art is in managing the care; the costs will follow."

Lyons came to Scripps in 1986 following her residency in primary care at UCLA and a short stint at Kaiser Permanente. Early on, she says, the West Coast was ahead of the East in its awareness that health care was changing. "It's inescapable; the economic imperative is much too strong," she says. But she also believes it's for the best.

Lyons promotes capitated programs—50 percent of Scripps's members are covered under such programs—because, she believes, they are the best for physicians. "Capitation becomes the financing vehicle that allows physicians the opportunity for a dignified practice of medicine, free from the straightjacket of external utilization review," she says. It frees physicians from arguing with insurance companies and from worrying about getting paid. In turn, this allows them to think creatively about how to keep their patients well and about how to effectively manage chronic conditions. "Scripps Clinic has unveiled some truly impressive stuff to help patients get care," she says. "This is the reason I went to medical school," she says.

Lyons highlights just a few examples. One is an outreach surveillance program in which patients with chronic conditions are telephoned daily or weekly depending on the illness. For example, patients with congestive heart failure are called up, asked what they weigh that day—often going to the scale with phone in hand—and then a caregiver tells them how to adjust their medication accordingly.

With an eye towards averting higher costs down the road in hospitalizations, Scripps provides for typically uncovered services, such as mental health benefits and things like eyeglasses, "so people can see and don't fall down and break their hips." Scripps also encourages flu vaccines. "It's cheaper to vaccinate the entire senior population than to hospitalize our members for pneumonia."

Although a staunch advocate herself, Lyons acknowledges that not all physicians feel the same way, and this worries her. "The more physicians put their heads in the sand, the more others, non-physicians, will come in and do it for them."

"It scares me to death when I see insurance companies attempt to manage care." She also points to legislative measures—i.e., mandating hospital length of stay following birth regardless of medical necessity—as an example of what can happen if physicians don't take charge.

"I say who is better situated collectively to respond to that challenge than the physicians?" She points to her own clinic as a model for a physician controlled organization. To order an MRI, for example, Scripps physicians adhere to a set of explicit criteria that have been defined by the physicians at Scripps. "We don't deny very often," says Lyons, and for the most part, physicians practice relatively independently. "It's only the highly variable parts of medicine that come under greater scrutiny." But if there is a review, it is done by the physician's own group, not by some outside judge.

"If we had to get permission from other insurance companies, we wouldn't be happy." And, because the physicians are organized, they can manage the risk involved.

Lyons says her classmates are just now "coming out of the woodwork" about managed care. She laughs. "Five years ago they gave me endless grief. Now they think I'm a prophet."

Terri L. Rutter

Netscape: Internet InfoCenter

Back | Forward | Home | Reload | Images | Open | Print | Find | Stop

Location: http://www.dec.com/info/internet/

What's New? | What's Cool? | Handbook | Net Search | Net Directory | Newsgroups

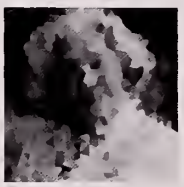
INTERNET UNIVERSITY

History of U.S. Medicine

Facilitator

George W.
Philadelphia

Larry B.
Minneapolis



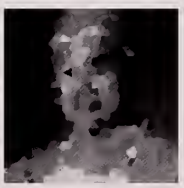
Linda T.
New Orleans

Barry R.
San Diego

Elizabeth G.
Toledo

Catherine D.
Marseilles

Yevgeny Y.
Moscow



Lee K.Y.
Singapore

James P.
Atlanta

Browse | **Listen** | **Touch** | **Taste** | **Search** | **Eject**

Back from the Future

by David Blumenthal

THE YEAR: 2095.
THE PLACE: the website of a highly regarded internet university.
THE COURSE: History of U.S. Medicine.

The dialogue begins.

FACILITATOR: Today, partners in learning, I want to continue our discussion of the U.S. health care system toward the end of the twentieth century. Yesterday, we reviewed the forces that led up to certain changes in the organization and financing of health care at that time. These forces included the increasing percentage of U.S. national wealth that was devoted to treating illnesses—in excess of 14 percent of the Gross National Product—and the consequent rebellion of other segments of society against the health care industry.

Hard as it is to imagine today, in cities like Boston, Philadelphia, Chicago and Houston, there were as many as four or five large hospitals with thousands of beds and tens of thousands of employees. A number of these were so–called "teaching hospitals" because they were sites of education for young doctors. That, of course, was long before the perfection of virtual reality on the internet allowed home–based medical education.

Anyway, in some of these cities, and throughout the United States, the health care industry was actually one of the largest. Ten to fifteen percent of the local work force was employed in this sector. A substantial portion of the nation's disposable income was expended on health care, and thus could not be used to purchase the other goods and services that were marketed at the time. This accumulation of wealth in one industry prompted a fierce competitive response from other industrial sectors.

Much health insurance at the time was purchased by employers for their employees. These employers banded together in "purchasing organizations" to negotiate with health care providers for reductions in the costs of health care. This created opportunities for middlepersons—called "managed care organizations" or MCOs at the time—to act as agents for purchasers and to recruit groups of providers who were willing to provide health care at lower cost. For a while, this divide-and-conquer strategy worked quite well from the purchasers' standpoint, and prices of health care plummeted. A quite competitive market ensued...

GEORGE W., PHILADELPHIA: Yeah, but that didn't last long, did it? Pretty soon, the providers got the U.S. Congress to relax certain laws—antitrust laws, I think they were called—and all the doctors and hospitals got together and formed their own organizations, and divided up the territory, and affiliated with national chains of providers who coordinated their negotiating strategies across different regions and...

LARRY B., MINNEAPOLIS: That's right. You got huge groups of purchasers fighting with huge groups of providers, and the result was a kind of standoff.

FACILITATOR: What happened as a result of this evolution from uncontrolled expansion of the health care system to purchaser–induced competition and then to a stalemate between consumers and suppliers of health care?

LINDA T., NEW ORLEANS: The nation's expenditures on health care stabilized at around 14 percent of GNP, and actually began to decline somewhat as the economy expanded, and fell to about 12 percent of GNP by 2005.

FACILITATOR: Yes, it is hard to conceive in retrospect that expenditures could have continued to increase at the previous rate of two to three percent in real terms in each year. What else happened?

BARRY R., SAN DIEGO: I think one of the most interesting things is what happened to the medical profession. Throughout much of the twentieth century, doctors were licensed to practice medicine by state governments. They had to take certain classes and written tests, work like indentured servants in teaching hospitals, and then they got licenses to practice medicine from the government. Only doctors could prescribe all those primitive drugs and barbaric tests they used at the time, or put people in those hospitals. You know, they actually cut people open then to remove cancers and stuff!

With those licenses, doctors could go into independent practice, and a lot of them did. They set up small offices, and patients came to them one by one.

They made a big deal at the time of the "patient/doctor relationship." It was sort of like the "parent/child relationship." But when the purchasers got together, and the managed care organizations did their thing—well, it became impossible for individual doctors to survive. They didn't have enough clout in the market to compete for patients and negotiate good payment rates from MCOs, and they didn't have the capital to develop new systems that would provide all the information that purchasers demanded on quality and other things. So they all joined groups of doctors, groups coalesced and got bigger, and pretty soon, virtually all doctors were members of big health care provider organizations. There was no more independent practice, and patients started relating to health care organizations instead of individual doctors.

That was the beginning of the end for the medical profession as it was known then, because if organizations were mostly responsible for providing care, then they could be held accountable for quality and cost, not the doctor. The organization was the key thing to regulate, if there was to be any regulation at all. It was just a matter of time until the licensure of medicine was abolished, though it did take until 2075 for the last state government to stop licensing doctors.

ELIZABETH G., TOLEDO: Personally, I don't think that doctors lost their professional status because of health care organizations. I think other things happened. Patients got empowered by the internet, which was just created around that time, and by the whole industry that developed to help them manage their own health problems. It started out as what they called "demand management." The idea was you could cut down on health care costs by educating patients to demand less health care. Well—that let the genie out of the bottle!

The first step was these services where patients could call nurses on what they called "800" numbers—free telephone services—to get advice about whether people needed to see a doctor. The next step was Medicine On Line, which was a service that would provide you with a whole diagnostic protocol if you just typed in your symptoms. You could have your electronic medical record encoded and sent to MOL, so that they didn't have to ask you everything each time you logged in with the sniffles. They could give you a diagnosis sometimes right there. Other times, you could just click on a button, download a diagnostic protocol, and have it sent to your health care organization. It would send a technician to your house or your office to draw your blood (they had to draw blood for lots of tests then) or whatever. Then you could log onto MOL later in the day and get your diagnosis and your treatment plan.

The other thing was that a lot of diseases just went away when they finally got serious about dealing with air pollution, banned cigarettes, and figured out that fat was really good for you. They realized that it was just when you had that virus that changed how fat was metabolized in your artery walls that humans got heart attacks and strokes. Medicine just became a whole lot less important. When was the last heart attack recorded in the United States, by the way?

FACILITATOR: It was 2070 in rural Mississippi. A 65-year-old African–American woman who lived her whole life with almost no medical care, so she never got vaccinated.

CATHERINE D., MARSEILLES: I am glad that we finally are talking about the biology, because from my perspective in the Union of European States (UES), much of what we have been discussing is quite beside the point. Certainly, there were perturbations in the way the health care system was organized in the United States in the latter part of the twentieth century and the early part of the twenty-first. I must say that the Americans had a formidable way with abbreviations—HMOs, PPOs, EPOs, IHCSs, MCOs, NCQA, GHAA, HIAA, AMA, ACP, AARP, COGME, AAMC—fortunately, none of this derangement was really very important for more than a passing few decades.

From my point of view, the most important development in the late twentieth century of the U.S. medicine was its leadership in the revolution of biology. This was important to the whole world! The whole human race!

First, you had the discovery of the double helix configuration of DNA in the 1950s, then the development of recombinant DNA technology and the monoclonal antibodies in the 1970s, then the polymerase chain reaction and so on. This, we liken to the work of the great European physicists of the early and mid–twentieth century: Curie, Einstein, Bohr, Rutherford, Fermi. Then you had the development in the early 2020s of reliable, widely applicable techniques for treatment of genetic defects in human beings. This we liken to the Los Alamos Project of World War II—though obviously with very different purposes. These are things that changed the course of human history, while also making medicine unrecognizable.

Second, you had the revolution in noninvasive technology, such that it is almost never necessary anymore to place an instrument inside the human body for diagnostic or therapeutic purposes—no more surgery, no more catheters, no more needles. Admittedly, this came later, but I point to it for perspective.

Why spend so much time talking about whether doctors worked alone or in organizations, and whether you spent 13 or 15 percent of your national product on medicine at that time? It is possible to do so much more for people now to help them. We are so much healthier as a race. In the year 1995, the life expectancy in the United States was only 75 or 76. Now it is over 100! In the sweep of history, the important things were biology and technology.

FACILITATOR: Very interesting point, Catherine. I was waiting for a contrarian viewpoint. Perhaps, all we need to study is the history of science!

YEVGENY, Y., MOSCOW: I agree generally with Catherine, but I also disagree. In Russia, we understand how much it matters how people do their business with each other. As you are aware, about this time we are discussing, we in Russia broke down our egalitarian state and started a new state modeled on your capitalist systems of the time. The result was great inequality among peoples and much suffering in our population, even while we modernized as a country overall. We should not ignore the effects of the events that occurred in the United States in the late twentieth century on the distribution of health care among different parts of the populace.

As I understand the readings, the competition that occurred in the health care system during the last years of the twentieth century caused quite serious suffering among working class Americans. Many of them lost their health insurance as employers stopped offering it in order to cut costs. Then these workers could not find insurance because they were no longer part of groups that could bargain for cheap coverage. And many of the sick could not find anyone who would cover them or provide care for them. It was even legal for an employer to stop paying for someone's insurance as soon as they became sick.

Thus, at a time of international ascendancy, the United States had this great paradox. Such a modern, efficient economy, such wealth and yet such poverty and suffering right along side it! The numbers of citizens without any financing of their health care increased to some 70 million—one-quarter of the population—by the year 2010. This included many middle-class individuals who were working full time, and even some wealthy people with serious illnesses.

There were marches on Washington and hunger strikes. Eventually, the national government had to step in to guarantee that everyone had health insurance. But we should not forget the great pain that so many people experienced. This is a lesson also for the whole world about how ideological solutions to social problems can lead to pain and dislocation.

LEE K.Y., SINGAPORE: Yes, but this period of great dislocation did have its benefits. It shrunk the U.S. health care system down very dramatically, which was necessary for this economy to maintain its international competitiveness, especially in light of the Asian economic miracle. Many hospitals closed, and many doctors lost their jobs before providers banded together to fight back. This shrinkage had to happen to free resources for more productive activities. These are the sacrifices that communities make for their own good. Unfortunately, the United States has historically been such an anarchic society—with so little discipline among its citizens and such rampant selfishness—that it subjects itself to the most painful excesses in order to obtain the goals that places like Singapore get to very directly and painlessly through communal action.

JAMES P., ATLANTA: A lot of people did get a kick, though, from seeing all those high-flying doctors driving cabs at night to keep body and soul together.

FACILITATOR: Well, James, it takes all kinds. Next week friends, I hope we will hear more from our African and South American colleagues. We will be covering the period from roughly 2020 to 2050. This is the period when advances in information technology made it possible for the whole world to gain access instantaneously to medical services offered anywhere else in the world. Thus, for the first time, health care became an exportable service and an international competition ensued for market share. The United States briefly dominated this market—a development which helped to greatly substitute for the continuing erosion of its competitiveness in the manufacture of many other products. Later, of course, this market came to be dominated by our friends in the Asian subcontinent.

Until then, happy and profitable surfing!

David Blumenthal MD, MPP is HMS associate professor of medicine and of health care policy and chief of the Health Care Policy Research and Development Unit at Massachusetts General Hospital.

photo courtesy of Marilyn Richardson

Before Their Time

by Guillermo Sanchez

Statue of Hygeia, sculpted by Edmonia Lewis, marks Harriot Hunt's gravesite in Mt. Auburn Cemetery in Cambridge.

Recent celebrations of 50 years of women attending Harvard Medical School have revived interest in the first to have been admitted to the school 145 years ago. Other women may have attempted it earlier, but the persistent Harriot Hunt was the first one to succeed, however fleetingly. Her story in some ways is not unlike that of another nineteenth-century woman who succeeded despite the odds, the sculptor Edmonia Lewis.

Harriot Kezia Hunt was born in 1805 in the North End of Boston, the daughter of Joab, ship joiner and merchant, and Kezia Wentworth. She attended Miss Carter's private school and with her sister, Sarah, founded a girls' school in which both taught from 1835 to 1875. The sister was sickly and was an invalid for several years, probably from tuberculosis, in spite of the vigorous ministrations of several respected physicians. She was eventually restored to health by a couple of irregular British doctors, the Motts, who relied on botanical remedies and hygiene.

The two Hunt sisters became increasingly interested in medicine, and after an initial apprenticeship with the Motts, established a highly successful practice. Sarah concentrated on children until 1840, when she married and started a family of her own.

Harriot specialized in women, with emphasis on problems particular to their sex. Her therapy stressed a concern for women's emotional and spiritual needs, with recourse to homeopathic remedies, diet, bathing and exercise. One of Hunt's biographers describes her as the "first successful woman physician in the United States." The size of her estate tends to confirm this opinion.

Hunt showed a lifelong interest in feminist causes, which probably explains her continued attachment to the Shakers. An offshoot of the Quakers popularized in this country by Ann Lee, Shakers were organized into thriving communal groups, lived in celibacy, and had a charismatic fervor that led to their name of Shaking Quakers. They held a central belief in the dual deity, Christ, the male, and Mother Ann, the female. The sect has dwindled to eight people, who live at Sabbath Day Lake in Maine. Hunt was also interested in other religious groups and maintained an active relationship with the Swedenborgian Church, which she eventually joined.

In 1843 she organized a Ladies' Physiological Society amongst her patients and friends. She wrote: "If women could be induced to meet together for the purpose of obtaining a knowledge of physical laws, it would enable them to dispense in great measure with physicians, put them on their own responsibilities, and be a blessing to themselves and their children."

After a dozen years in successful medical practice, Hunt felt an increasing need for a more formal medical education. In 1847, encouraged by the outgoing dean, Walter Channing, she applied to Harvard Medical School, "to seek for the scientific light to place my mind in more harmony with my professional duties..."

Her application was referred to the new dean, Oliver Wendell Holmes Sr., who passed it on to the president of Harvard and the Harvard Corporation. They expressed "a decided feeling against the promiscuous attendance of the Sexes on the anatomical lectures" and considered her admission "inexpedient." (It should be remembered that in the nineteenth century "promiscuous" had no special sexual connotation and corresponded to our "random.") A contemporary of Holmes, David W. Cheever, describes Holmes's attitude: "his kindly nature inclined him to the claims of the opposite sex, but he voted with the majority for prudential reasons."

Holmes, however, appears to have encouraged Hunt to apply again in 1850, and this time she was successful. Holmes's cover letter to her application mentions that R.I. Blackwell had been accepted in 1847 by the Geneva Medical College (from which she graduated) and that a Female Medical College of Massachusetts had been founded earlier in the year. "No objection was perceived to admitting female students to the lectures, but that no opinion was expressed...as to the claims of such students to a medical degree."

Unfortunately for her, two other contentious issues arose at Harvard Medical School that same year: the trial and hanging of the professor of anatomy, John White Webster, for the murder of his colleague George Parkman and the application and acceptance of three black students, including the prominent abolitionist Martin Delany.

The medical students were unanimous in their opposition to Hunt. "Resolved, That we object to having the company of any female forced upon us, who is disposed to unsex herself and to sacrifice her modesty, by appearing with men in the medical lecture room."

The three men who had paid their fees were allowed to complete a term, but were prevented from continuing. Hunt, who had not paid yet due to illness, according to her autobiography, was persuaded to withdraw her application and never reapplied. Her name does not appear in the "Catalog of Students Attending Medical Lectures, 1850 to 1851." She was given an honorary MD by the Female Medical College of Philadelphia in 1853 and continued with her thriving practice and her lectures on women's health.

A few other women applied to Harvard Medical School in later years and were invariably turned down, until 1945 when the first nine were enrolled.

Around 1854 Nancy B. Clarke, a graduate of Cleveland Medical College, settled in Boston, allowing Hunt to "feel more at liberty to leave home when there were other women in the same profession." In 1855 Hunt went on an extensive tour of New York and Ohio; she visited Oberlin

photo courtesy of Countway Library, Rare Books

College with particular interest. "That place whose fame was bruited abroad, because education there was for mind, not sex or color." She was somewhat disappointed in that "There seemed to be a lack of cheerfulness...the sphere at Oberlin seemed to me one of constraint; I questioned whether the soul had free play, whether there were amusements enough to recreate and unbend the mind." She next visited Antioch College, another institution sympathetic to young women's intellectual needs.

In 1871, after many more years of successful practice, Hunt, already afflicted by a serious kidney illness that led to her death four years later, dictated in her will that "No bill be sent to any of my patients," leaving to their discretion "any amount of which they feel they may be indebted."

She left a trust of $1,000, "The income arising annually therefrom for the purchase of medical textbooks for women within the New England States." And further: "I give and bequeath to the Home for Aged Colored Women one thousand dollars. And a similar amount for the Soane Fund, for income annually arising therefrom."

The will gives other detailed instructions for the distribution of a very sizable estate for that period, with specific gifts of four houses and $11,500. It includes in its first paragraph the following: "The moiety now due Edmonia Lewis, the sculptor, for my statue of Hygeia, to be based on my lot which is to be delivered to me June 1872)... to be met when delivered."

This documents the intersection in 1871 of the lives of two important nineteenth-century figures who shared the doubtful distinction of having had the prejudices of their day frustrate their academic ambitions, though not their academic careers.

Who was Edmonia Lewis and how had she reached this degree of prominence? Some of the details of her life and origins are debatable because in describing them she could be vague and at times deceptive. Mary Edmonia Lewis was born probably in 1845 in Greenbush, New York near Albany, although she claimed to have been born and brought up on the Chippewa Indian reservation.

The exact date of her birth and her genealogy are uncertain. She insisted that she had not a drop of white blood. Her mother, Catherine Mikne was a member of the Mississango branch of the Chippewa tribe, probably with some African blood in her veins. Her father, Samuel Lewis, she described as completely black, "a gentleman's servant," likely born in Haiti.

Mary Lewis, orphaned at an early age, grew up in New Jersey and Boston in spite of her later claims of having been brought up on the reservation "in the same wild manner... fishing and swimming and making moccasins." She referred to her Indian name as "Wildfire," linguistically a most improbable term. Her brother Samuel, a barber in Bozeman, Montana, went west during the Gold Rush and was successful. He offered to send his sister to school and, in 1859, she went to Oberlin College, an extraordinarily liberal institution which accepted women (1833) and blacks (1835).

Lewis, in the Young Ladies Preparatory Department, studied composition, literature, botany, the Bible and linear drawing. She lived in the house of the Reverend Wood with two other female students, who later

accused her of having poisoned their mulled wine with Spanish fly. Members of the irate college community dragged Lewis out of her house and beat her severely. She was tried and was successfully defended by a young black lawyer, John Mercer Langston, later a member of Congress and the founder of Howard Law School.

She resumed her studies, but was accused of stealing paint brushes from a local artist. Although acquitted again, she was prevented from registering for subsequent college terms. At various times she expressed her frustration at never having been allowed to study anatomy. During her college years she produced a drawing of Urania, and for the first time signed herself "Edmonia Lewis."

With her brother's help and funds from the sale of an edition of the bust of Colonel Robert Gould Shaw, she was able to move to Rome, where a group of American female artists led by Harriet Goodhue Hosmer were creating impressive sculpture, although they were dismissively described by Henry James as "a white marmorean flock." Hosmer had studied anatomy with her physician father and at St. Louis Medical College. She welcomed Lewis and arranged for her to use the studio formerly occupied by the famous sculptor Antonio Canova.

In 1871 Lewis returned to Boston, where she met Harriot Hunt and was given the commission for a statue of Hygeia, goddess of health and daughter of Asclepias. (The statue, considerably weather-beaten, is in the center of the Hunt burial plot in Mt. Auburn Cemetery in Cambridge.) In 1873 Lewis held exhibitions in California at local fairs, in booths shaped like wigwams. The last documented visit with friends in Rome is described in a letter by Frederick Douglass to his brother in 1887: "She seemed happy and cheerful and successful." We know nothing of her later years or her death, although the Catholic *Who's Who* in 1909 mentions her as "advanced in years, she is still with us."

Thus the lives of two extraordinary nineteenth-century women intersected: Harriot Hunt, a successful physician who was blocked from attending medical school, and Edmonia Lewis, a talented black-Indian sculptor, who was unable to study anatomy as she wished, and was drummed out of Oberlin College on trumped-up charges. Both women, in spite of major obstructions to their careers imposed by gender and ethnic prejudices of their day, surmounted obstacles and are remembered today as pioneers and role models for later generations.

Would they have accomplished more if they had completed their studies as they wished? The opposite is just as interesting to contemplate: might such careers have attenuated their tenacious drive?

Guillermo Sanchez '49 is an HMS assistant clinical professor of internal medicine and a member of the editorial board of the Harvard Medical Alumni Bulletin.

The author is deeply grateful to the biographers of Edmonia Lewis, Marilyn Richardson, and Timothy A. Burgard (Fogg Museum) and also to Richard Wolfe (Conntway Library), Sylvia McDowell (Schlesinger Library), and Patrice Donahue (Harvard University Archives).

Photo of Edmonia Lewis courtesy of Boston Athenaeum